Conceptualizing ORGANIZATIONAL HEALTH - Public health management and leadership perspectives

Orvik, Arne

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CONCEPTUALIZING ORGANIZATIONAL HEALTH

– PUBLIC HEALTH MANAGEMENT AND LEADERSHIP PERSPECTIVES

BY
ARNE ORVIK

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Akershus University Hospital [cover photo]

Conceptualizing
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- Public health management and leadership perspectives

Arne Orvik

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PhD supervisor: Professor Runo Axelsson
Department of Sociology and Social Work
Faculty of Social Sciences
Aalborg University

Assistant PhD supervisor: Docent Susanna Bihari Axelsson
Department of Sociology and Social Work
Faculty of Social Sciences
Aalborg University

PhD committee: Professor Janne Seemand (chair.)
Aalborg University

Professor Karsten Vrangbæk
University of Copenhagen

Professor Elisabeth Fosse
University of Bergen

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About the author

Arne Orvik (born 1952) graduated as a Cand.Polit. in Health Sciences at the University of Bergen in 1997. His degree also included studies of diacony, nursing, pedagogy, management, and economics. Since 1985, he has worked at the Department of Health Sciences at Aalesund University College, which recently became part of the Norwegian University of Science and Technology (NTNU). He has taught nursing students and master students at different university colleges and published a textbook on organization and leadership in health care. For periods of years, he held managerial positions in the Department of Health Sciences and, recently, a part-time position as an adviser at the Centre for Health Promotion at Akershus University Hospital.

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This thesis is therefore dedicated to my family

March 2016

Arne Orvik

Abstract

Aim: This thesis aims to contribute to the development and conceptualization of organizational health, including its potential implications for public health management and leadership. This is achieved through a conceptual and theoretical analysis, and through a synthesis of empirical findings.

Methods: The research design of this study is based on a combination of inductive, deductive, and abductive reasoning. For the most part, qualitative methods are used and supplemented by mixed methods. A hybrid model of conceptual development guides the research process: the empirical findings are informed by theoretical reflection, and in the final synthesizing phase, the analyses of elements are informed by a postmodern hermeneutical approach.

Findings: The thesis introduces a new conceptual model of organizational health and discusses its implications for public health management and leadership. The model is developed with reference to organizational theories and ideologies, including New Public Management, the use of which has coincided with increasing workplace health problems in health care organizations. The new conceptual model introduced here is based on empirical research and theories in the fields of public health, health care organization and management, and institutional theory. It includes five dimensions and defines organizational health in terms of *how an organization is able to cope with the tensions associated with diverse values and competing institutional logics.* This definition calls for a tricultural approach to understanding the tensions between values associated with quality, efficiency and integrity, and a dialectical perspective when attempting to assess the integration as well as the disintegration of such values. Possible implications of this model for public health management and leadership include four different forms. The application of the conceptual model can potentially draw attention to value conflicts and help to clarify contradictory, institutional logics. It can also potentially support managers in dealing with work health problems not only on an individual and group level, but also on an organizational and interorganizational level.

Conclusions: This thesis argues that a conceptual model of organizational health needs to be informed by an inverse value pyramid (i.e. a bottom-up rather than a top-down approach), and a differentiation between the health *of* an organization and the health impacts of an organization *on* people. The conceptual model bridges work health, organizational health and public health, and includes interorganizational and collaborative dimensions. The conceptualization and implications of organizational health in this thesis indicate that there are four key forms of management and leadership in health care organizations: hybrid management, value based management, value conscious leadership, and a combination of health promoting and servant leadership.

Keywords: efficiency; health professionals; health promoting leadership; hybrid management; integrity; public health; quality; servant leadership; value based management; value conscious leadership; work health.

List of papers

I Orvik, A. & Axelsson, R. (2012). Organizational health in health organizations: Towards a conceptualization. *Scandinavian Journal of Caring Science;* 26 (4): 796-802; Doi: 10.1111/j.1471-6712.2012.00996.x

II Orvik, A., Vågen, S.R., Bihari Axelsson, S. & Axelsson, R. (2015). Quality, efficiency and integrity: Value squeezes in management of hospital wards. *Journal of Nursing Management;* 23 (1): 65-74. Doi: 10.1111/jonm.12084

III Orvik, A., Nordhus, G.E.M., Bihari Axelsson, S. & Axelsson, R. (2016). Interorganizational collaboration in transitional care: A study of a post-discharge programme for elderly patients [Accepted for publication in *International Journal of Integrated Care*, the 8th February 2016].

IV Orvik, A. (2015). Values and strategies: Management of radical organizational change in a university hospital. *The International Journal of Health Planning and Management;* Doi: 10.1002/hpm.2332

V Orvik, A., Larun, L., Berland, A. & Ringsberg, K. (2013). Situational factors in focus group studies: A systematic review. *International Journal of Qualitative Methods;* 12: 338-358.

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Chapter 1:

Introduction

Health care organizations could be models for developing healthy organizations. They are personnel intensive and engage a large number of people. They are also knowledge and research intensive and dependent on the competence of professionals who also need special attention given to their work health and wellbeing. These characteristics make work health in health care organizations a significant issue in public health. Traditionally public health has been defined as the science of promoting health through *organized* community efforts (Acheson, 1988). More recently, the definition of public health has drawn on wider interdisciplinary research about the health impacts of health care systems, environments and social structures (Ejlertsson & Andersson, 2009). Such research has also included assessments of how policies, regulations and incentives can facilitate organized responses to health challenges (Laverack, 2014).

Recent research has also identified management and leadership as critical elements in the building of organizational capacity for work health promotion, and for creating strategies, structures and cultures for health-promoting workplaces and values (Eriksson, 2011; Hoffmann *et al.*, 2014; Pelikan *et al.*, 2014). These newer approaches have focused attention on organizational considerations when evaluating work health. Transdisciplinary concepts have also focused on bridging occupational and organizational health, as well as methods to identify health determinants on an organizational level (Bauer & Hämmig, 2014). However, until recently, approaches from the field of management and leadership have only occasionally been applied to work health issues in health care organizations. This thesis aims to introduce a new conceptual model of organizational health in the context of health care and other human service organizations.

Chapter 2:
Background

Cultural changes in health care organizations

In knowledge and service organizations, the increasing focus on organizational change and productivity has led to the recognition that there is an urgent need to identify the relationship between organizational climate, leadership, health, and productivity (Arnetz & Blomkvist, 2007). In the health care sector, this focus on change and productivity has coincided with the expansion of health care services and the concurrent rationalization of service provision. A comprehensive study of Norwegian municipalities concluded that the rationalizations in the sector have had predominantly negative effects on work health, particularly on risk factors such as work intensification in health care organizations. The review called for a consideration therefore of both competitive performance *and* working conditions at an organizational level (Westgaard & Winkel, 2011).

Other studies indicate that focusing only on productivity and on internal, organizational effectiveness in terms of the throughput of patients, is a one-sided approach, which may have a potentially counterproductive impact on the quality of patient care. Crawford and colleagues (2013) argue that a production-line approach to care delivery appears to have intruded into the discourse of clinical practice in ways that may have compromised best practice and increased time pressures and stresses on health professionals as well as clinical managers. The language inspired by the production-line approach, they conclude, is indicative both of an institutional mentality and of an emotional distancing between practitioners and patients, despite the fact that the delivery of a quality service is a core objective of health care organizations.

Many of the changes which have taken place in the health care sector have been inspired by the ideas of New Public Management – an approach that has seen the application of the management principles of the private sector in the public sector (Hood, 1989; Pollitt, 1990). These changes have meant implicitly that there has been a transition in human service organizations from being institutions based on human values to ones that operate more as enterprises, which are focused on economic values. In the last few decades, a number of organizational changes of this kind have taken place in the health care systems of the Nordic countries (Axelsson, 2000; Byrkjeflot & Neby, 2008; Jespersen & Wrede, 2009). All Norwegian hospitals, for example, have introduced an explicit enterprise organizational approach (Torjesen, 2008). However, according to Busch and Murdock (2014), the application of New Public Management may have failed to deliver on promises of greater efficiency and organizational effectiveness.

During the last few decades, there have been increasing work environment and work health problems among health professionals in Nordic health care organizations. Such problems include high turnover and burnout (Borritz *et al.*, 2006; Glasberg *et al.*, 2007), sickness absence, and sickness presence where professionals go to work in spite of their impaired capacity to work (Elstad & Vabø, 2008). Other issues include negative stress, exhaustion and depression (von Vultée *et al.*, 2007; Arman *et al.*, 2012), high workloads, time pressure, difficult work situations (Blomberg & Sahlberg-Blom, 2007), moral distress (Kälvemark *et al.*,

2004, 2007), anxiety, and even death (Hasson, 2006). In the Nordic countries, the prevalence of sickness absenteeism and sickness presenteeism, in general, is higher in public human service organizations than in other sectors of society (Aronsson & Gustavsson, 2005; Vinberg & Landstad, 2014).

Analysing work environment and work health issues in Nordic health care organizations requires attention to gender concerns. A Norwegian report concluded that although sickness absence in the health care sector is high, it is not especially high compared to other sectors if statistical data are adjusted for the fact that eight out of ten employees in the health sector are women (NOU 2010:13). Work health problems are significantly higher among women in all sectors in Norway. However, organizational perspectives on work health in health care organizations and other sectors of society draw attention to the fact that work health is not only about women's health issues, but should be seen instead as a wider public health issue.

The extent of health problems among health professionals could be regarded as paradoxical, and has been described as a crisis of the soul of health care workplaces (Wilson & Porter-O'Grady, 1999). The societal mandate of health professionals and health managers, after all, is to promote health, including work health. Work environmental and health problems in the health sector have ripple effects for patients, families and communities. Moreover, the application of New Public Management principles appears to be associated with an increase in health problems within health care organizations. This problematic relationship has also been observed in other public service organizations in which New Public Management has been introduced – for example in municipal units (Korunka *et al.*, 2003; Noblet *et al.*, 2006).

The ideology of New Public Management is based on the management principles of the private sector and a concern for productivity and economic efficiency. As such, it is a management system oriented mainly towards public service users or customers (Pollitt, 1990). In health care organizations, this means that the orientation towards patients may become primarily informed by economic concerns rather than concerns about people. In performance based payment systems, the priority is to increase the number of patients treated rather than providing a higher quality of care. This concern for productivity and efficiency is based on economic values quite different to the traditional human values one might associate with patients and professionals in health care organizations. Tensions between these different values have affected working conditions and increased levels of stress among health professionals and clinical managers, and may have had negative impacts on their work health (Forsberg *et al.*, 2001, 2002; Järvholm *et al.*, 2013; Bäckström *et al.*, 2014).

Value tensions such as these are common, too, in other human service organizations. The work quality of individuals working in welfare services has been impacted, for example, by an increase in customer orientation – a change which has been strongly associated with high levels of stress and high rates of sickness absence among professionals (Marklund *et al.*, 2008). The negative effects of value tensions on work health can be particularly problematic in health care organizations. An appropriate conceptualization and an understanding of the phenomenon of organizational health in the health care sector are therefore particularly important.

The concept of organizational health

Traditionally, work health challenges – even in the Nordic countries – have been described mostly on the individual or group level (Angelöw, 2002; Menckel & Österblom, 2002). It is crucial, however, that managers have the appropriate terminology and methods to describe and promote health on an organizational level, too, if they are to deal with work health problems and value tensions among health professionals. This is particularly so given that most of the value tensions they face seem to be associated with competing organizational logics and values. Within such contexts, the development of a concept of organizational health could potentially help to broaden the horizon and understanding of work health (DeJoy & Wilson, 2003). This is because such conceptualizations enable work health problems within health care and other human service organizations to be explained by organizational characteristics on different levels of analysis (cf. Marklund *et al.*, 2008). In this thesis, the need for the development of a new conceptual model of organizational health is rooted in Nordic organizational contexts. However, the development of this conceptualization is also based on concepts and empirical findings from diverse fields related to health services and on organizational research from different countries.

As noted above, the focus of this thesis is on the concept of organizational health. The theoretical framework presented below includes public health, institutional, and setting perspectives, and health promotion perspectives could be included in this framework. This is because the concept of *organizational health promotion* provides a useful supplement to that of organizational health. Moreover, I suggest that a focus on organizational health promotion helps to strengthen the public health relevance of the concept's development, and helps to expand the scope of worksite health promotion. One of the main arguments in this thesis is that efforts to improve the health of the workforce and expand the health promotion capacity of an organization should begin with the organization itself. Organizational health promotion is rooted in the basic fabric of an organization – including how work is organized (DeJoy & Wilson, 2003). Using such an approach points forward to the setting perspective presented below.

Extensive work health problems have also been documented among unskilled workers in health care services, such as those employed in kitchens and laundries (e.g. Gunnarsdóttir & Björnsdóttir, 2003). Work health issues affecting non-professional groups and even non-health professional groups, may also be linked to conflicting values in health care organizations, and provide a useful platform for conceptualizing organizational health. However, the focus of this thesis is on the work health of *health professionals*. Other groups, such as managers – including clinical managers in hospitals and municipalities, who have responsibility for patient care as well as budgets – are also considered.

Middle managers face greater work intensity and an increase in role demands, especially in the public sector (McCann *et al.*, 2008; Bäckström *et al.*, 2014). Cross-pressures and value squeezes in these roles may be linked to integrity pressures and associated work health risks, and should therefore be included in considerations of organizational health. The work health problems faced by administrative and top managers, too, also influence upon the sustainability of organizations, even though the challenges they face may be different from those faced by clinical leaders. I would argue therefore that an organizational approach to work health issues

in health care organizations should include a consideration of the work health of *all* employees, including managers across *all* organizational levels. This fundamental premise forms the foundation of the conceptual analysis throughout this thesis, and is in keeping with a systemic and holistic view of organizations. As Saunders and Barker (2001) have suggested, such holism is crucial to understanding organizational health.

Thus far, specialists have used organizational health mainly as an abstract, 'sensitizing' concept. According to Blumer (1970), the deepening of the conceptual substance of a sensitizing concept occurs through a continual process of interpretation and modification. In the process of developing the concept of organizational health, both experience-distant and experience-near concepts must be considered. According to Geertz (2000), experience-distant concepts are employed by specialists or researchers to reflect their practical or scientific aims. In contrast, experience-near concepts are used by social actors to express what they see, feel or think. In experience-near concepts, ideas are naturally and indissolubly bound up together, as Geertz suggests, with the realities they inform. Social actors apply experience-near concepts spontaneously and readily understand them when they are used in similar ways by other social actors. However, as Geertz points out, while using experience-near concepts, social actors seldom recognize that there are any 'concepts' being used at all.

The experience-near reflections of professionals and managers on the processes challenging work health in daily work life should be integrated into conceptualizations of organizational health. Such reflections are particularly significant when a conceptualization is being undertaken using a broader horizon of what is understood to be work health. For health professionals and managers, terms such as 'stress' and 'squeeze' are potentially valid ways of describing the work health challenges they face, and descriptions like these can be integrated into a model of organizational health through analytic induction.

In the conceptualization of organizational health, different experience-distant concepts are also essential. In addition to the concept of organizational health itself, other experience-distant concepts such as organizational climate (Hoy & Fedman, 1987), organizational schizophrenia (Melander, 1999) and organizational discrepancy (Nielsen & Randall, 2012; Andersen & Westgaard, 2015) can also be incorporated in the processes of interpreting and modifying a conceptual model of organizational health. These additional concepts may be compatible with or in opposition to the concept of organizational health. Experience-distant concepts can enable professionals and managers to conceptualize and deal with the workplace tensions they face on an abstract level. However, experience-distant concepts may also gradually change from being experience-distant to being more like an experience-near concept.

I therefore argue in this thesis that a conceptualization of organizational health, which is valid in the context of public health management and leadership, should incorporate both experience-distant and experience-near concepts. This is especially the case in an era in which workplace health is recognised as increasingly important, and given a growing body of empirical knowledge on workplace health promotion in general (Torp et al., 2011: Torp, 2013), and in health care services in particular (e.g. Järvholm *et al*., 2013; NOU 2010:13).

A dialectical approach to organizational health

In the literature on work health, concepts such as occupational health, worker health, healthy workplaces, and workplace health promotion have traditionally been used to describe and analyse health issues in organizations (Polanyi *et al.*, 2000). These concepts have focused mainly on individuals and the group dimensions of health in the workplace, but organizational dimensions have recently begun to be included (Chu *et al.*, 2000; Shain & Kramer, 2004). The issue of sustainability has also become central to contextual approaches to health promotion in the workplace (Rootman *et al.*, 2001) but, so far, it has been poorly defined and researched in the field of health care (Anåker & Elf, 2014). Despite the increasingly broad understandings of organizational health, the concept itself has seldom been used explicitly – either theoretically or empirically – in the literature of public health and health promotion. When it has been used, organizational health has been discussed mostly in relation to workplace stress, organizational stress, and wellbeing (Cooper, 2011; Cartwright & Cooper, 2014), and in relation to models of healthy leadership in which healthy leaders are presented as the cornerstones of organizational health (Quick *et al.*, 2007).

The concept of organizational health, however, has been used for a long time in management literature, mostly as an abstract idea of what constitutes a 'good organizational structure' (Drucker, 1955). It has also been used to 'diagnose' organizations and as a means of identifying pertinent designs and strategies for organizational development (Levinson *et al.*, 1972; Weisbord, 1978). In empirical research, the concept of organizational health has been used, for example, as the basis for assessments of the organizational climate of educational institutions (Hoy & Fedman, 1987), in studies of industrial restructuring and downsizing (Adkins, 1999) and, more recently, in studies of occupational health that have focused on organizational contexts (Macintosh *et al.*, 2007; Macik-Frey *et al.*, 2007). In the general literature of management, the concept of 'health' has often referred to the health of organizations (Westgaard & Winkel, 2011).

Few empirical studies of organizational health, however, have been undertaken in health care organizations. In a study of organizational health in an American hospital, Winker (1996) defines the concept in general terms seeing it as the ability of an organization to create and foster value symbols which provide meaning to the internal and external participants in an organizational culture. Another study noted that hospitals with a high level of organizational health are distinguished by an internalization of vision and mission among employees, close relations within the work environments of health professionals and managers, and a value based management approach (Leggette, 1997). More recently, researchers have linked improvements in organizational health to individual and organizational capacity building in hospitals and collaborating health services, and to the quality systems in such organizations (Pelikan *et al.*, 2014).

The development of a new conceptual model, I would argue, can be undertaken by recognising how the concept of organizational health is linked to the competing institutional logics and value tensions within health care organizations. This necessarily requires an organizational level of analysis (Tummers *et al.*, 2002) in the development process. It also requires a dialectical perspective when analysing organizations – one which focuses on the diversity and conflicts of logics and values, as well as on mutual dependencies (Benson, 1977). Embedding a dialectical perspective in the analysis of organizational health implies a recognition that there are tensions between values such as quality, efficiency and integrity, and that there are mutual dependencies between such factors, too. This more complex understanding is important if

health care institutions are to achieve both sustainability and societal effectiveness, and thereby improve public health.

The development of a new and different approach within the field of organizational health is inevitably influenced too by a researcher's pre-conceptions and experiences. Such "conceptual baggage", as Kirby and McKenna (1989) suggest, should be made explicit. It should be noted that my research interest has been influenced by the many years I have spent teaching health professionals and clinical managers. These experiences have enabled me to recognise the apparent tensions between the professional values and the role expectations of workplaces. My professional background in the diaconal, human and health sciences has also probably intensified my interest in these value tensions and my critical insights into the core assumptions of New Public Management. In addition, my experience in different management positions may also have influenced my research interest.

Chapter 3:
Overall aims and research questions

The overall aim of this thesis is to develop a new conceptual model of organizational health for use in health care organizations and to scrutinize the possible implications of organizational health for the management and leadership of such organizations and units. The development of this conceptualization focuses on two main research questions:

- How can organizational health in health care organizations be developed in terms of a public health perspective?
- What are the possible implications of organizational health for public health management and leadership?

The conceptualization developed is based, firstly, on a review and analysis of the relevant literature (Paper I). This analysis is then deepened through an assessment of studies of different aspects in specific organizational and managerial settings in public health care services, namely:

- The value squeezes of quality, efficiency and integrity and their impacts on the management of hospital wards (Paper II)
- The interorganizational collaboration in the intermediate care of the elderly, and the potential effects of the collaboration on quality and efficiency (Paper III)
- The value orientations and strategies for dealing with value tensions associated with the management of radical organizational change at a university hospital (Paper IV)

The purpose of the conceptualization in this thesis is to describe organizational health theoretically and, at the same time, to seek specific knowledge limited to health care organizations settings, and health care management and leadership. This dual aim requires the application of both nomothetic as well as ideographic approaches. In the context of this thesis, a *nomothetic* approach allows for the universal nature and content of organizational health to be substantiated by seeking relevant knowledge from different disciplines and research areas, mainly within the fields of organizational and management theory. An *ideographic* approach, on the other hand, allows for the contextualization of organizational health within specific health care settings, and for the analysis of findings from such settings to be viewed in the context of the different dimensions of organizational health. Such a combination of approaches presents particular methodological and epistemological issues.

Chapter 4:
Theoretical framework

The thesis is guided primarily by empirical research and theories in the fields of public health, health care organization, management and leadership. It also draws on institutional theory.

Public Health

The Ottawa Charter outlines actions to achieve the goal of 'Health for All' by the year 2000 and beyond, and was presented at the First International Conference on Health Promotion in 1986. The Charter defines health promotion as *"the process of enabling people to increase control over, and to improve, their health"* (WHO, 1986). To reach a state of health, the Charter suggests, individuals and groups must be able to change or cope with their environments. This broad understanding of health encompasses both individual as well as structural factors, and suggests that health is a resource for everyday life – a resource that serves a purpose beyond merely sustaining life. Necessarily, by including environmental and structural dimensions, this definition of health suggests that an organizational approach is needed when attempting to understand work health and achieve health goals.

A reformulated health concept

While the official WHO definition of health is widely accepted, Huber and colleagues (2011) suggest that it provides little opportunity to understand health from a resource perspective. They contend that there is a need to move towards a more dynamic, conceptual framework of health, which is centred upon the capacity to cope, maintain and restore integrity, equilibrium, and a sense of wellbeing. These researchers are inspired by environmental scientists who have described the health of the earth as the capacity of a complex system, within a narrow range, to maintain a stable environment. They characterize human health as a set of dynamic features and elements and suggest, as a starting point, that health should be reformulated as the ability to adapt and to self-manage. This reformulation, they argue, involves three domains: physical health, mental health, and social health. In the social health domain, which includes work settings, health can be understood as a dynamic balance between opportunities and limitations, and is one in which people are able to achieve their potential, meet their obligations, and also able to manage their life with some degree of independence.

All three domains are of potential relevance to an assessment of organizational health. However, it is the principles and values inherent in the social health domain that are particularly important to conceptualizing organizational health. As noted above, the domain of social health includes work settings. From a social psychology perspective, workplaces can be regarded as primary groups and sources of events that can potentially influence the health of employees. In the domain of social health, issues such as independence and integrity – the latter of which is the state of being integrated in an organizational environment (cf. Schabracq, 2003) – must also be considered. A deeper understanding of issues related to work settings, including

independence and integrity, enables the contextualization of work health issues. For this reason, these are included in the framework of organizational health described below.

A settings perspective

According to Green and colleagues (2000) three of the most common approaches used in health promotion are a focus on issues, a focus on populations, and a focus on settings. In the context of organizational health, the inclusion of concerns related to settings is particularly relevant given that health, as the Ottawa Charter states, *"is created and lived by people within the settings of their everyday life; where they learn, work, play and love"* (WHO, 1986). Settings impact upon health, and changes in settings such as work reorganization and the implementation of new technology should therefore be subject to systematic assessments of their health effects. A focus on settings, I argue, is particularly useful given that it enables the identification of opportunities for promoting health in socially defined contexts. Potentially, it can also identify ways in which health promoting efforts can be implemented.

Dooris (2004) argues that a settings approach should include three key components to promoting health: the creation of supportive and healthy environments; the integration of health promotion into ordinary activities in the settings; and the development of collaboration between different settings. Focusing on these components can prevent health promotion activities and functions from being seen as a 'side-car' in organizations, integrated within core activities but insufficiently integrated into the general management (Frick, 2004; Eriksson, 2011). A settings perspective incorporates an examination of management at different organizational levels, including the management of interprofessional and interorganizational collaboration and integration. It also suggests that there is the potential for the creation of healthy environments for patients as well as for health professionals and managers.

Green and colleagues (2000) highlight the importance of context-sensitive perspectives to work health promotion by noting how settings define the subject, the choice of location, and the framework of health interventions. Most health promoting activities are bound within particular settings, and these provide the social structure and context for the planning, implementation and evaluation of health interventions. Further, Thorlindsson (2011) reasons that transdisciplinary approaches and the integration of components from different disciplines and different types of analysis can deepen context-sensitive perspectives and develop better theories and more efficient ways to promote health. A social science framework, it can therefore be argued, strengthens the system approach to public health and health promotion (Thorlindsson, 2011; Green, 2006) and, more widely, the promotion of organizational health in health care organizations. For this reason, my analysis also incorporates institutional theory.

Sustainability

The notion of sustainability in public health is also relevant to the organization of healthy workplaces. Thus far, sustainability has been understood mostly in terms of the development of the personal resources of employees and the promotion of individual health as ways of increasing productivity and efficiency. More recently, organizational issues have also begun to be incorporated into considerations of sustainable work and healthy workplaces. Westgaard and Winkel (2011) suggest that there is a need to understand the health effects of organizational change to ensure that sustainable production systems are thought of from long-term

perspectives. They also argue that to maintain competitive production systems, rationalization should be understood as a never-ending process in which there is continuous adaptation to changing contextual factors. According to Kira and colleagues (2010), sustainable work relates both to personal resources *and* to the interior and exterior worlds of employees. They propose that the concept of traditional manager-led job-design should be expanded and contextualized, and that it should incorporate a consideration of the work processes of employees and the multiple organizational factors involved in such processes. Even more explicitly, Anåker and Elf (2014) argue that the concept of sustainability could be integrated within health care organizations by including a fundamental core of knowledge in which the work environment, holism, maintenance and long-term perspectives are integrated.

These and other setting approaches (e.g. Whitelaw *et al.*, 2001) indicate that focusing only on the health behaviours of individuals is insufficient if sustainability is to be achieved. Instead, attention should also be given to changes in actual organizational settings, as health problems and health solutions are both located within settings. According to Torp (2013), solutions are therefore closely related to the key activities performed in such settings. If sustainable health changes are to be achieved in the context of work health among health professionals and managers, it is not sufficient to focus only on their individual health. Instead, attention should be given to the changes required within the organizational contexts of the problems and to the key activities performed there. This approach, necessarily, has implications for both the management and leadership of health care organizations.

Settings approaches have been criticised for implying that settings are simply a means to achieving health promotion. However, I would argue that the contextualization they provide is vital: an understanding of what is actually happening in settings is a prerequisite for promoting health in such settings. This approach is especially pertinent to organizational health in health care settings, because such settings are particularly contradictory and complex systems, and often associated with high levels of stress among professionals and managers (Davidson *et al.*, 2011; Arman *et al.*, 2012). The contextualization of settings requires discovering how work is organized and what the underlying organizational values and institutional logics are that may influence it. To ensure sustainability, organizational health activities must be seen as integral to the basic organization fabric.

Health as integration and disintegration

From a holistic perspective, individual health can be characterized as an oscillation between integration and disintegration (Eriksson, 1989; Pörn, 1995). In the context of work health, the process of being integrated into a work setting or organizational environments can affect individual health. Such a contextual approach to health asks that we recognise the different social levels that influence individual work health, and is seen by some researchers as a more realistic and useful approach to health promotion (Thorlindsson, 2011). At times, integration may not occur, but this absence may also sustain the health of individuals. Being ‘disintegrated’ in a work setting or work environments, it can be argued, may be a necessary individual reaction to negative stresses associated with incompatible role expectations. This may occur, for example, during mergers or radical organizational change in work settings. Stress research can therefore also provide us with insights into organizational health (Cartwright & Cooper, 2014).

Health care organization, management and leadership

Traditionally, public health management has been seen as synonymous with the management *of* health care organizations. However, through the lens of a philosophy of health promotion, public health management may also be regarded as a form of management *for* health. This latter orientation places emphasis on managerial and organizational efforts to promote health in health care settings, and shifts the focus more towards organizational determinants than individual determinants. The advisory organization, Management Sciences for Health, provides a useful example of how this different approach to organizational management can be applied: it has embarked on building sustainable programmes and leadership capacity for human resources to support stronger systems for greater health impact (WHO, 2015).

At the same time, a wider shift from a focus on the traditional administration of health care services towards the management and leadership *for* health, has accentuated the importance of applying such approaches to the development of welfare systems in general. This change also implies a shift away from a focus only on formal organizations towards one which also includes informal organizations, networks, partnerships and different models of collaboration between organizations. Collaboration between professions, organizations and sectors is important to promoting sustainability in the context of public health, particularly given the multifaceted nature of health needs within a complex society (Rootman *et al.*, 2001).

Both a management *of* health and a management *for* health approach draw on structural, procedural and cultural perspectives within the institutional field of organization and management. All three perspectives are potentially relevant to analyses of organizational health, and can be used either separately or in integrated ways. However, the cultural approach, with its focus on values and a hermeneutical interpretation of organizational knowledge, seems particularly valid given that values contribute to organizational culture (Aadland, 2010). At the same time, organizational cultures and the socialization of diverse professional and managerial groups and subcultures in healthcare also add to the considerable heterogeneity of value systems within health care organizations, and lead to competing institutional logics and conflicting values within such organizations (Graber & Kilpatrick, 2008).

Health professionals and managers, in some instances, may be more committed to the values of their own profession than to the values of a health care organization (Hernes, 1996, 2001). This suggests that health care organizations can be intensively infused by multiple logics and competing values. To deal with such tensions, professionals in management may adopt a hybrid, multiprofessional management role. In such roles, the logic of management can be supplemented by other professional logics, some of which will be inconsistent and some of which will be overlapping (Berg, 2015). Hybrid managers may also be governed by other logics, in addition to professional and managerial ones. Pettersen and Solstad (2014) argue, for example, that clinical managers in hospitals may also experience and operate according to communicative or political logic. This ‘triangle’ of logics may change and form different patterns, they reason, according to particular contexts and the professional backgrounds of the managers concerned. Glouberman and Mintzberg (2001) have suggested further that four logics, and the friction between the clinical world (‘care’ and ‘cure’) and the managerial world (‘control’ and ‘community’), are also characteristic of health care organizations.

According to Scott and colleagues (2000), the logic of managerial authority and control has been the most pervasive challenge to the traditional values of health care organizations. This tension between the managerial and the clinical domains has been characterized as a state of

organizational discrepancy, particularly among stakeholders at different organizational levels, but also in networks, partnerships and other forms of collaborating organizations (Nielsen & Randall, 2012; Andersen & Westgaard, 2015). The concept of organizational discrepancy, according to these researchers, refers to divergent mental models and potentially conflicting perceptions and appraisals of quality and efficiency measures. In the context of this thesis, it is particularly interesting that they even suggest that there is a connection between organizational discrepancy and poor individual and organizational health and functioning.

Hybrid management

In health care organizations, professionals manage their own personal daily work processes, some of which are also situated in the context of multidisciplinary teamwork. In the organizations in which they work, there may be intensive discussions regarding the substance and quality of service provision, and these may challenge the authority of managers as well as professionals. Communication between these two groups is often difficult because of the different roles and the different values and logics involved. Professionals may be more focused, for instance, on service quality, while managers may be more typically focused on service efficiency. According to Kouzes and Mico (1979), each domain operates according to different and contrasting principles, work modes, success measures, and structural arrangements, and interactions between the different domains create conditions for discord and disjunction. To promote integration and organizational health, new forms of public health management and leadership are therefore required.

Hybrid management attempts to draw together different domains, and hybrid managers often find themselves in roles which cross the border between the professional domain and the management domain, acquiring combinations of professional and management knowledge and identities (Gillies & Greenwood, 1997). Such hybrid combinations are traditional in hospitals: physicians and nurses, for instance, often cover 'clinico-managerial' roles and retain both a professional role as well as a managerial identity (Jespersen, 2005; Wikström & Dellve, 2009). The combination of different roles and domains within hybrid management suggests that managers need to consider different logics and change dynamics, and to deal with potential polarization or antagonism between these different domains.

In the disciplines of medicine and pharmacology, antagonism refers to the physiological forces that tend to work in different and opposing directions; some interactions may also lead to favourable outcomes (Rang & Dale, 2007). In organizational research, antagonism is typically rooted in conflicts between multiple different and contrasting interests (Devos, 1998). Antagonism can also be caused by cultural differences between managers and employees (Timming, 2007). However, even in instances of organizational antagonism, there are mutual interdependences that exist between the diverse values and forces within organizations. A form of dependence can be necessary to achieving organizational outcomes. Organizational antagonism can therefore be understood as being more than a clash of interests and forces working in opposite directions. Instead, it can also be characterized by mutual dependencies between diverse values and logics (Orvik, 2015). Hybrid managers may have to deal with apparently incompatible organizational values, but tension and dysfunction should not be seen either as inevitable or negative. Instead, such tensions may also be indispensable and vital elements of healthy organizational processes.

Hybrid management, it can be argued, is more than simply the management of polarized values because it also involves attempts to integrate different values or ways of organizing, and achieving a balance between these. At times, top-level managers may be required to ignore quality norms because of budget constraints. Some operating at a clinical level may argue that a resource perspective is needed, in which the norms of individualized patient care and professional integrity are sustained. Similarly, hybrid managers may also face budgetary problems but may need to balance these against professionals' concerns. These may, for example, be about the negative effects that budget cuts and downsizing may have on the quality of patient care. At the same time, they may also be asked to balance these against concerns about the impacts that changes may have upon the integrity and associated health risk factors for the professionals.

At other times, the aim of hybrid management may be seen as the facilitation of the *disintegration* of different values or ways of organizing. In such cases, stresses within hybrid management reflect a polarisation between managerial values and professional values (Jacobs, 2005). Such polarisation may occur both at the micro level as well as at the meso level. To maintain their integrity, middle managers recruited from health professionals may develop non-negotiable strategies guided by their own inner commitments, convictions and basic values (Bergin, 2009). In this type of value disintegration, hybrid managers, in effect, sustain value conflicts by supporting their professional colleagues; at the same time, the importance of values related to economic efficiency may complicate the communication and collaboration between management and professionals. Hybrid management, in these instances, involves organizational antagonism and the promotion of certain values, at the expense of others. The polarisation and disintegration between managerial values and professional values also occurs at the macro level. In the United Kingdom, for example, there have been political initiatives promoting partnerships with the welfare professions as part of attempts to give more importance to their associated professional values in public organizations. This, however, may have been at the expense of considerations related to economic values (Similä & McCourt, 2011).

Hybrid management roles may be adopted willingly or reluctantly. In Finland, the medical profession was 'hybridised' in the 1990s through the adoption of the management accounting techniques associated with New Public Management. Professionals in the United Kingdom, in contrast, have strongly resisted the intrusion of accounting practices into the medical domain (Kurunmäki, 2004). Hybrid management has been associated with a dialectical negotiation of conflicting professional identities and leadership identities, in which managers sustain dual identities and navigate between their professional roles and leadership roles (Sørensen *et al.*, 2011). For example, ward management in hospitals requires the balancing of both quality and efficiency concerns, and may be regarded as a form of hybrid management, because of its combination of clinical and administrative responsibilities. The 'two-way-windows' of hybrid management, as Llewellyn (2001) argues, enable hybrid managers to look into – and act in – two different worlds instead of having to operate within one particular world only. However, the individual norms of public health care managers may conflict with organizational norms (Dellve & Wikström, 2009). While some managers may agree with changes and reforms, on some occasions they may protest if the focus on the quantification of work is perceived to be at the expense of the quality of health care delivery (Arman, 2010).

A hybrid role may implicitly be associated with value dilemmas because managers and professional colleagues must cope with competing logics and value conflicts. As such, hybrid management in health care settings is far from trouble-free. Inherent conflicts can be brought

about for example, by the closeness and distance of hybrid management to clinical practice (Witman *et al.*, 2011; Sørensen *et al.*, 2011). Hybrid management efforts may, at times, be more closely aligned with administrative concerns or may lean more favourably towards the concerns of employees and support the development of partnership with managers. At other times, this cohesion may fragment if different logic systems compete against each other at the same time. Hybrid managers might choose to 'tune in' or 'tune out' of different logics, depending on the tasks at hand (Wikström & Dellve, 2009). They can therefore be seen as occupying a special role as 'translators' of different organizational logics between levels or organizations.

Other models of hybrid management include the use of hybrid teams as a way of reducing the professional and emotional costs for those in hybrid management roles. The use of shared clinical leadership between two managers, instead of relying on one hybrid professional with the responsibility of balancing competing logics (Choi, 2011) is a further alternative. One manager, for instance, could be made responsible for decisions within a professional arena, while another could operate in an administrative arena.

Hybrid management was introduced in Nordic countries and a number of other western countries in the wake of New Public Management. In these settings, it is generally expected that hybrid roles will be transformed into general management roles that focus primarily on economic values (Berg *et al.*, 2010). However, hybridization may also be part of progression towards a new, post-New Public Management era (McNulty & Ferlie, 2004; Choi, 2011). This would be a positive change, for as Christensen and Lægreid (2007) contend post-New Public Management reforms will need to re-establish a cohesive culture of trust, collaboration and common ethics that can build a strong and unified sense of values and value based management.

Alternative hybrid strategies incorporating aspects of value based management into hybrid management (Graber & Kilpatrick, 2008) may be useful in achieving change. However, Öfverström (2008) has questioned the value of both hybrid management and value based management. She has argued that while hybrid management roles are beneficial in theory – because they enable two disparate worlds to be integrated in and translated through one person – there is little empirical evidence to suggest that such solutions are practical. Likewise, value based management has been found to be difficult to implement, especially when those involved are strongly driven by their own professional norms and values (Payne, 2000). Further clarification and critical reflection on the incorporation of aspects of value based management into hybrid management are therefore needed.

Value based management and value conscious leadership

All forms of public health management and leadership are guided by health promoting goals and values and, as such, may be regarded as value 'impregnated'. Value based management, however, differs from other forms of management in its *use* of values as management tools and as a source of motivation and energy (Aadland, 2004). In short, as Aadland (2010) states, values are about valuing and evaluating. He argues that values are broadly defined as preferences, and include professional ideals as well as economic assessments. Aadland also argues that the interrelationship between values and actions is close, but not closed, and that values can be extracted from actions through reflection and interpretation. In a classic definition of values, Kluckhohn (1951) differentiates between three types of values, namely the cognitive, the

emotional, and the motivational. Value based management integrates all these aspects, and as House (1996) suggests, is associated with a manager's ability to express a value based vision and to create an ethical engagement among employees (Busch, 2011).

The importance of value based management has been demonstrated by empirical studies of organizational health in hospitals (Winker, 1996; Leggette, 1997). More recently, value based management has become increasingly popular in Nordic health care and has been implemented in hospitals. In a Swedish study of professional hospital groups, participants understood value based health care to be care which is focused on how value is created for patients, on measuring medical outcomes and costs, and on strategies to loosen the grip of economic control (Andersson *et al.*, 2015). The study also indicated that it was the professionals' perspectives on what the patients should value that appeared to dominate participants' understandings of value based health care. One conclusion was that the concept might have been understood in a way that omitted elements of the original meaning.

Value based management approaches are rooted in the disciplines of sociology and moral philosophy, and highlight the values and attitudes in organizations reflected in dialogues between managers and professionals (Petersen & Lassen, 1997; Thyssen, 2002). Some have argued that the need for value based management has intensified due to the plurality of values in the societal environments in which health care organizations are located. The coexistence of different value systems and the fragmentation of value systems in society could lead otherwise to parallel communities of quite different meanings and value interpretations (Aadland, 2009). In this context, value based management could be seen as contributing to greater value consciousness and help people to make sense of the organizations in which they work (Weick, 2001).

It is imperative that diverse values are properly managed in health care organizations. If they are not, this may lead to value tensions and a 'schizophrenic' organizational state (Melander, 1999). To prevent this from happening, value based managers may sometimes need to integrate different values systems. At other times, value based managers may themselves contribute to organizational disintegration if they prioritize particular values over others – for example, by placing patient and professional values ahead of service production values. In the context of New Public Management, value based managers may find it difficult to explain why options related to increasing efficiency through reorganization, mergers or cuts in the workforce are less possible or less potentially desirable in health care organizations compared to organizational settings such as industrial enterprises.

Integrating diverse values in health care organizations when responding to and managing value tensions may be possible. Doing so would help to challenge the prevailing economic paradigm of New Public Management. However, this will require new ways of thinking about – and enacting – public health management practice, and a focus on *public* values to influence service delivery and, at the same time, addressing the supposed weaknesses of New Public Management (O'Flynn, 2007). Maintaining and managing such value tensions, I would suggest, can be done within the framework of value based management. Like hybrid management, value based management could provide unique opportunities to mediate between different sets of cultural values and provide an opportunity for managers to act as translators between different organizational logics and levels. This, for example, could help to prevent minor workplace problems from leading to major problems for patients, for health care organizations, or for society. A combination of hybrid and value based management may

therefore be a promising way to progress towards a new, post-New Public Management era (McNulty & Ferlie, 2004).

Sustainable strategies for dealing with competing institutional logics and value tensions call for *value based* management, as well as *value conscious* forms of management and leadership. While value based management is anchored in established values, value conscious leadership refers to the development of values or to the coming into being of values (Busch, 2011; Busch & Murdock, 2014). Because health care organizations are infused by diverse logics and value tensions, the development of a theoretical framework for organizational health must also draw on institutional theory, which is presented in more detail below.

Health promoting, servant leadership

In addition to hybrid management, value based management and value conscious leadership, some others theories are highly relevant to the task of conceptualizing organizational health. Particularly, the following forms of leadership should be included: health promoting, altruistic, transformative, appreciative, communicative, caritative, and servant. Servant leadership has elements associated with value based management, value conscious leadership and institutional theory, and will therefore be described in greater detail and integrated further with health promoting leadership.

Health promoting leadership can be an implication of organizational health as well as a means to the promotion of organizational health. Health care organizations are particularly concerned with developing and implementing sustainable workplaces. A Swedish study by Eriksson *et al.* (2010), for instance, found that health promoting leadership was regarded as a comprehensive leadership approach that included individual and structural dimensions in the building of organizational capacity for health promoting workplaces. The study showed that the integration of health promoting leadership into management practice requires broad participation by employees in the planning and design of such programmes. Because of its explicit focus on work health and wellbeing of employees, health promoting leadership is conceptually linked to servant leadership, which is more detailed below.

Altruistic leadership is oriented towards the activities of others, for example, in connection with interprofessional and interorganizational collaboration. An altruistic form of management may challenge other types of management such as New Public Management that tend to ignore problems of horizontal integration (Christensen & Lægreid, 2007). Altruistic orientations presume that health professionals and managers are willing to see their activities in terms of the needs of patients and the wider society, and support the notion that comprehensive processes may be required to help people to learn how to do so. According to Bihari Axelsson and Axelsson (2009), a key focus in altruistic leadership is the development towards a more visionary form of leadership, and in this context, how professional and managerial roles can be transformed.

Transformative leadership is opposed to transactional leadership, which is focused on clear roles and a top-down form of social transaction, and is a system in which labour is exchanged for rewards. In contrast, transformative leadership focuses on daily operations and procedures, and is rooted in ethics and relations. It aims to develop employees through an emphasis on the value of their self-confidence and self-management (Sørensen & Uhrenfeldt, 2011). This more charismatic form of leadership builds on trust, specific values and ideals, and requires loyalty. Of crucial importance is a leader's ability to motivate followers to realise the benefits beyond

the expected, and beyond the boundaries of their own self-interest. Transformational leadership is concerned with creating a sense of commitment among employees to an organization by strengthening their participation and thus their motivation (Eriksson-Zetterquist *et al*., 2012).

Appreciative leadership is based on an affirmative mind-set and characterized by positive expectations for both managers and employees, and focuses on the possibilities that challenges present (Espedal, 2010). This form of leadership is also known as Appreciative Inquiry (AI) – a system that seeks to enhance the personal development of employees and emphasizes the added value and innovations in organizations (Sparvath, 2011). Appreciative leadership shares common elements with transformational leadership, particularly the focus on recognizing and praising employees, and involves them in decisions. Appreciative leadership is therefore also associated with communicative leadership.

The term *communicative leadership* refers to the typologies of communicative versus strategic rationality, first introduced by the sociologist and philosopher Jürgen Habermas (1984). The communicative form of leadership is characterized by involvement and equal status in relationships, and can strengthen the acceptance of decisions made by organizations and increase their legitimacy (Nordby, 2009). A study of a Swedish municipality concluded that the development of a common set of values in the health care service necessarily required a communicative leadership style, respect for individual employees, and a respect for the wider organizational and professional cultures that emerged in the health care service over time (Trollestad, 2000; Kihlgren *et al.*, 2009).

The core idea behind *caritative* leadership is that of serving others – a notion which lies close to the original concept of administration: 'ad ministrare', meaning 'to serve' in Latin. According to Foss (2011), in health care settings, the patient is both 'the other' and the true leader. In this model, leadership is therefore seen as being independent of an organizational context. This interpretation of leadership is rooted in a caring tradition in which leadership involves ministering to patients through the creation of a culture of dignity, quality and safety (Bondas, 2003). Such forms of leadership are central to the operations of humanitarian and diaconal movements such as the Red Cross and the Blue Cross. The realization of caritative leadership and patient-centred care requires that a consciousness of such values remains continuously among professionals and managers, but the use of caritative leadership can be determined by economic circumstances. This form of management can also counteract the effects of organizational structures, which can oppress patient-related values and time for helping, counselling and reflection, and which can potentially increase distress among health professionals (Kälvemark *et al.*, 2004; Bentzen *et al.*, 2013). In this way, caritative leadership, value conscious leadership and servant leadership can be understood as being conceptually connected.

Like caritative leadership, *servant leadership* is also infused by ideas and values related to ministering. While caritative leadership is primarily patient-centred, the horizon of servant leadership is that of the professional and personal development of employees. However, the achievement of positive patient and staff outcomes is the ultimate goal of servant leadership (Gunnarsdóttir, 2014). The modern conceptualisation of servant leadership was developed in the 1970s (Greenleaf, 2008), but the notion of ministering and servant leadership can be traced back to early Chinese philosophy and later to a Christian diaconal tradition.

According to Greenleaf the core concept underlying this form of management is that of the 'servant-leader'. Notably, the primary emphasis in this form of leadership is upon the servant

component first, rather than the leadership component. This is important because, traditionally, leaders – unlike servants – are regarded as leader first and being motivated by power and material goods. Leaders who understand themselves primarily to be servants must prioritize the empowerment of others by helping them to grow through increased independence, wisdom and health and to develop a serving style themselves, in the next round. Greenleaf's vision is that of a better society created by people serving one another. Organizational researchers, such as van Dierendonck (2011), have noted that servant leadership can help to empower and develop people. However, it could also be argued that other and better ways of developing and empowering health professionals may be more appropriate to doing so.

Servant leadership, it should also be noted, is more of a philosophy than a specific leadership style. Nevertheless, servant leadership perspectives are important in terms of what they can tell us about the implications and importance of job satisfaction and the performance of employees (Garber *et al.*, 2009). Empirical studies in the context of health care services have shown that there is a link between servant leadership approaches to work health and public health, and particularly to organizational sustainability (Gunnarsdóttir, 2014). Servant leadership has also been shown to be associated with healthy work environments for staff and patients (Kramer & Schmalenberg, 2008). Supportive leadership by servant leaders can also help to reinforce trust, humility, social cohesion, and shared goals – all of which characterize the Nordic style of management and leadership (Smith *et al.*, 2003; Gunnarsdóttir, 2014).

These associations between servant leadership and sustainability, work health and public health, and the explicit linking of servant leadership to the professional and personal development of employees are the main reasons for including servant leadership in the theoretical framework of this thesis. Such findings are also important because they highlight the connection between servant leadership and health promoting leadership. An additional reason for including the concept of servant leadership in this framework is the core idea of the institution as a servant – for this is what links this form of leadership to considerations of ethics and to institutional theory.

Institutional theory

The connections between values, management and leadership described above point to the relationship between institutional theory and the study of health care organizations. Busch and Murdock (2014) suggest that the concept of value based management can be traced back to institutional theory, which has gradually become a framework for management and leadership in public organizations such as hospitals (Pettersen & Solstad, 2014). Institutional theory is more closely aligned to the ethos of pre-New Public Management practices – an ethos which is centred around values, norms and history, as well as the outcomes of service delivery and long-term effects on users, citizens and society as a whole (Modell *et al.*, 2007). In spite of these associations between institutional theory and values, and the relevance of the theory for conceptualizing organizational health, the criticism of institutional theory can also be helpful.

Berger and Luckmann (1967) argue that institutions are themselves socially constructed, and Scott (2008) highlights the importance of the roles of individuals and collective actors in the processes of institutionalization, as well as to the survival of institutions. These perspectives reflect, therefore, the importance of including patients, professionals and managers, and associated human values, as parts of the process of conceptualizing organizational health within an institutional frame. New-institutional theory in sociology has been critically assessed particularly for its lack of interest in the social actors in institutions (Kirchhoff, 2013).

Institutional theory has been critically assessed, too, for its undervaluation of how organizations influence their environments. Scandinavian institutional theory is thus particularly relevant to this thesis because it focuses on how organizations as institutions define, create and form their environments, and vice versa (Eriksson-Zetterquist *et al.*, 2012). The concept of the organizational field is important to such considerations and is elaborated below.

Institution

From a traditional sociological perspective, organizations become institutions by being infused with values (Selznick, 1957) and are socially constructed. In essence, this suggests that organizations as institutions are constituted by the actions of individuals and organizations (Berger & Luckmann, 1967). Institutions, as such, are more than just instruments for the provision of specific services and their construction is not necessarily informed only by technical considerations. This means that institutional values go beyond organizational values that are relevant to the tasks. Values are also a constitutive part of the process of institutionalization and contribute to the development of a distinctive culture and specific competencies in organizations (Eriksson-Zetterquist *et al.*, 2012). Through their underlying logics of values and action, institutions shape heterogeneity and stability, but also provide opportunities for change (Thornton & Ocasio, 2008). However, institutions and institutional values can also impair change.

To become institutions that have a high level of societal legitimacy, organizations need to comply with societal values (Busch & Murdock, 2014). Processes of institutionalization also contribute to deeper intrinsic, institutional values in organizations, and Scott (2008:48) describes three institutional 'pillars' that can help to strengthen institutional values:

> *"Institutions are comprised of regulative, normative and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life."*

While *regulative* elements are comprised of laws, rules and sanctions, social obligations and expectations are embedded in *normative* elements. Scott (2008) characterizes *cultural-cognitive* elements as taken-for-granted, common, and shared, but also as contradictory logics. All three elements are crucial to understanding organizations as institutions. However, in the conceptualization of organizational health, the *cultural-cognitive* element and the related logics and values in health care organizations and society are particularly important.

Processes of institutionalization and the development of institutional values are also affected by action nets and organizational fields. While the concept of an action net implies that there are connections between actions, the organizational field forms the frame of reference for organizations dealing with the same types of activity (Lindberg & Czarniawska, 2006; Czarniawska, 2004). According to these researchers, connections between actions in an action net can be loose and temporary, however, even though they are often likely to occur within a specific organizational field. They emphasise that the concept of the organizational field does not necessarily capture direct interactions: organizations in the same field may only have virtual contacts or may even have no direct contact at all. Scott (2008) states that the concept of organizational field is particularly suited to the study of institutionalization and helps to bind the environments within which such processes operate.

Organizational field

Early sociologists defined an organizational field as a social arena and a system of organizations with common meaning. In the definition provided by DiMaggio & Powell (1983, 1991), an organizational field is described as the organizations constituting a recognized area of institutional life, including key suppliers, consumers, regulatory agencies, and other organizations producing similar services or products as field members. Membership in this sense draws upon Bourdieu's (1985) earlier conception of a field, and refers to settings in which agents with social positions in the form of habitus and capital are located, and struggle for power and resources. The concept of an organizational field also refers to the dynamic relationships existing between organizations as collective actors, to the totality of organizations and actors belonging to a particular field, or to the structure of a field or sector.

Scott (2008) notes that an organizational field can be understood as an area in which participating actors form a community and system of meaning through interacting more frequently and faithfully with one another than with other actors outside the system. In this way, he characterizes an organizational field as an analytical level that connects organizational studies to wider macrostructures at sectoral, societal and transnational levels. Scott also portrays an organizational field as a critical unit, and as such, one which bridges the organizational and societal levels, and is particularly appropriate to studies of change. Using this approach, I will argue that the concept of an organizational field is potentially relevant to the analysis of organizational health in a public health and societal context.

Institutional constraints imposed by authorities or influenced by professions or markets can lead to homogeneity or isomorphism in forms of organization. DiMaggio and Powell (1991) differentiate between coercive, normative and mimetic isomorphism. These can be associated, respectively, with the regulative, normative and cultural-cognitive elements referred to above. In a comprehensive, empirical study of changes in the organization of health care services in an American, metropolitan region, Scott and colleagues (2000) examined changes in a health care organizational field. Their conclusion was that societal-level impacts from government, from professions, and from managerial-market logics, had led to the field being transformed from one dominated by professional logics to one in which these latter three logics co-exist, but where no single one dominates.

During the two last decades, Scandinavian institutional theory has focused on how understandings of organizational standards have been translated into new organizational fields. The uptake of such ideas has been compared to the transmission of fashions (Røvik, 2007) and can be voluntary in nature. However, if used by an increasing number of collective actors, changing standards may lead to isomorphism within organizational fields (Eriksson-Zetterquist *et al.,* 2012), and organizations can be acting under constraint. In this thesis, the ideology of New Public Management and the application of management principles from the private sector in the field of public health care illustrates an 'ideal-type' of organizational recipe or standard. Such changes illustrate the close connection between the concept of the organizational field and the concept of institutional logic. As Thornton & Ocasio (2008) suggest, an organizational field is a level of analysis and a place where institutional logics are played out. Rather than theorizing isomorphism in organizational fields, they argue that an institutional logics approach views any context as potentially influenced by competing logics.

Institutional logics

The differentiation of society means that multiple frameworks that can be constitutive for organizations and individuals, govern different fields. In this context, an institutional logics approach has been introduced as a method of analysis to explore the ways in which specific fields work. According to Thornton and Ocasio (2008), an institutional logics approach provides a bridge between micro processes on the one hand, and the macro, structural perspectives on the other, by defining the content and meaning of institutions and by providing a link between action and institutions.

Early institutional theorists emphasized that each societal institution has its own logic constraining the means and ends of individual and organizational behaviour. More recently, however, theorists have stressed that each institution has multiple and competing logics. In their initial definition of institutional logics, Friedland and Alford (1991: 232f) described these as supraorganizational patterns of activity rooted in material practices through which human beings conduct their material life, but also as symbolic systems through which human beings categorize this activity and infuse it with meaning. Further, Thornton and Ocasio (1999: 804) described institutional logics as socially constructed patterns of practices, such as assumptions, values, beliefs, and rules, by which individuals organize time and space and provide meaning to their social realities.

Health services research conducted using an institutional logics perspective and a field-level perspective can illustrate the existence of competing logics. The study of Scott and colleagues (2000) referred to above, and similar investigations in the field of health care, have used methods of institutional logics. In a case study of the large health reforms initiated and led by a regional, Canadian government, Reay and Hinings (2005) developed a model to explain and understand change in mature organizational fields such as health care services. Understanding the competing institutional logics that were part of radical change was essential to understanding the process of field recomposition, particularly the later elements of field change. Rather than explaining the sources of change, these researchers investigated how a field becomes re-established after the implementation of radical change.

There have been noteworthy examinations of institutional logics and organizational fields in Nordic health services research too. Grape and Ineland (2013), for instance, refer to the Swedish tradition of an institutional approach to research on collaboration, and to the influence of regulative, normative and cultural-cognitive elements on organizational structures and professions. A Norwegian study of extensive change to the organization of work in nursing homes in response to health care reforms concluded that contradictory logics create incongruous events that nurses clarify through sense making (Kristiansen *et al.*, 2015). By combining an institutional logics perspective and the theory of sense making, and by demonstrating how sense making among professionals enables contradicting logics to co-exist, this study added to previous institutional knowledge in contexts of increasing standardization and efficiency demands in the field of health care.

Institutional logics and values

Values can be reinforced through institutional logics or by wider fashions and trends (Eriksson-Zetterquist *et al.*, 2012). When being embedded in the prevailing logics, neither values nor valuing can be understood as neutral phenomena. This association between institutional logics

and values is particularly important to the notion of competing logics and value conflicts, which form the central focus of this thesis. While this connection between institutional logics and values is implicit in the first definition referred to above, it is made more explicit in the definition of Thornton and Ocasio (1999) who argue that institutional logics, as socially constructed patterns of values, provide meaning to individuals in their own social realities.

According to Thornton and Ocasio (2008), institutional logics also structure attention by generating a set of values. These values order the legitimacy, importance, and relevance of issues and solutions and provide decision makers with an understanding of their interests and identities. These, in turn, generate a set of decision premises and motivations for action. Institutional logic is a method of multi-level analysis, which sees society as an inter-institutionalized system. In the context of conceptualizing organizational health, this focus on competition between alternative institutional logics and values is particularly essential.

In public services, both means and ends can be strongly anchored in values, and as such, health care organizations are institutions. Health institutions are mandated to promote health, and this presumes sustainable workplaces infused by human values. However, to be an instrument for the efficient production of specific services, economic values should also be incorporated in health care organizations. When influenced by economic values, a health care organization could be described as a health enterprise rather than a health institution. There is an implicit tension between these different views of organization, despite the fact that both play a key role in achieving the goals of health care organizations.

This tension between a health institution and a health enterprise is also reflected in the clustering of values. Between particular value clusters, considerable gaps may exist, and within each cluster, one value may dominate. According to Jørgensen (2006), a dominant value is also known as a nodal value, and has a large number of related neighbour values. A nodal value can be understood as being of greater importance than values which only have a few related values.

In this thesis, I first identified value clusters related to patients, production and professionals. Following this, the gaps and the connections between these clusters were articulated. During later stages of the conceptualization, quality, efficiency and integrity were identified, respectively, as nodal, dominant values within these clusters.

Quality and efficiency

Many health care managers have embraced roles that are deeply rooted in clinical contexts – roles that are characterized by a close relationship with professional colleagues, as well as patients. For example, some nurses who have initially been socialized as professionals and then enter management roles have described their management role as one in which they are ‘ministering’ to patients (Bondas, 2003). In their management roles, nurses are central to maintaining professional standards of care, and can have a fundamental effect on the quality of patient care (Bradshaw, 2010).

At the same time, the introduction of general management into health care has influenced significantly on the nurses’ management roles, especially on those who have been given enhanced responsibility and are expected to have managerial skills related to ensuring cost-effectiveness (Causer & Exworthy, 1999). Health management at different organizational levels may require close collaboration with top managers, especially regarding resource and

budget issues. Being professionals, health managers can be legitimately expected to promote the quality of care by highlighting clinical values in daily operations and change. Being administrators, health managers can legitimately be expected to promote efficiency by highlighting the values and economic goals of an organization. However, quality issues may cause dilemmas for managers as well as their professional colleagues.

In the literature on quality and patient safety, issues such as work organization, staffing, and clinical and educational standards are seen as increasingly important indicators of quality. For example, the RN4CAST survey of health care organizations in the European Union and the United States of America from 2012 indicated that nurses' workloads have a crucial impact on the survival of patients (Aiken *et al.,* 2014). One of the main findings in this large statistical overview was that an increase in the workload of a nurse by just one patient increased the likelihood by 7% of an inpatient dying within 30 days of admission. These findings illustrate considerably the basic value tensions in health care organizations between the quality of patient care and the efficiency of service production.

In organizational contexts, efficiency is usually defined as the ratio between resource inputs and production outputs. Effectiveness in such contexts is defined as the relationship between the outputs and the objectives (Shortell & Kaluzny, 2006). Efficiency may be detrimental to the quality of care, and vice versa, but quality may also be an important condition for efficiency (Nelson *et al.,* 2007). Thus, while there may be tensions between quality and efficiency, there is also a mutual dependency and an antagonistic relationship that exists between them: *both* may be seen as integral and conducive to organizational and societal effectiveness.

This tension between quality and efficiency affects not only the overall effectiveness of a health care organization, but also reflects the basic tension of these organizations as both institutions and enterprises, as noted above. Although there is a tension between quality and efficiency, both these organizational considerations are needed within health care organizations and services. As Cara and colleagues (2011) have suggested, a philosophy of caring and the reality of economic constraints can coexist when promoting quality in patient care. However, health professionals and managers should not only attempt to bridge the tensions associated with quality and efficiency values: they should also encourage and maintain value tensions in the health organization, as value disintegration can be essential to the promotion of organizational health. This issue is discussed in further detail below.

Integrity

Health care managers, working as both professionals and managers, often find themselves in buffer positions (Richard, 1997). This can lead to value conflicts and pressures on their integrity, causing work-induced health problems and, by extension, organizational health challenges. Traditionally, integrity has been regarded as a moral issue and relevant primarily on an individual level. However, integrity is more than an internal, personal concept. It is also connected to – and integrated with – wider organizational environments (Schabracq, 2003). Integrity may be understood in this regard as referring to the internal integration of individual functioning and the integration of an individual in his or her niche and, by extension, within an organization and within the wider society (Schabracq & Cooper, 1998). The concept of integrity can also be influenced by laws, for example, such as The Norwegian Working Environment Act, in which the concept has been included since 2005 (Directorate of Labour Inspection, 2013).

Schabracq (2003) describes three aspects of integrity, all of which are potentially relevant to organizational health and health care management. Firstly, integrity is shaped by whether a person is able to *work in accordance with her or his own values.* According to Schabracq, to act with integrity requires that individuals do not go against their own convictions. It is when individuals follow other dominant and conflicting values, he suggests, that their integrity breaks down. Health managers may wish to ensure the individualized quality of patient care but, at the same time, they must manage time and other resource shortages. As budget constraints and increasing demands for organizational efficiency become more and more dominant, it is likely that the integrity of health professionals and managers may also come under increasing pressure.

Secondly, integrity is determined by whether a person is *willing to do what it is that he or she is actually doing* (Schabracq, 2003). This form of integrity, which I would characterize as 'functional integrity', is one that appears to describe the decisions and actions taken in daily management and patient care. A state of integrity, it can therefore be argued, is one in which people are not mentally 'divided', and one in which the actions of professionals and managers correspond with their basic values. Achieving such an aspect of integrity may lead to less job stress and fewer work health complaints. Sometimes attempts to defend integrity may labelled mistakenly as resistance to change.

Thirdly, integrity is determined by whether individuals are *integrated in their environments.* In the context of health care organizations, the environment in which managers are located consists of people and professionals, as well as the health care organization itself. According to Schabracq (2003), integrity enables individuals to gain control over their functioning, helps them to establish a 'human territory', and contribute to good performance and personal development – all of which are conducive to better work health. Human beings, and the environment in which they are located, are not unrelated to one another. Rather, they are part of an overall, mutual system of influence. By maintaining integrity, professionals as health care managers are able to integrate themselves better into the organizational world of communication and social action, and this allows them, Schabracq suggests, to behaving in a meaningful way, to control their personal functioning and, to some degree, their surroundings.

In general, a state of integrity enables members of an organization to integrate themselves within a wider social structure, maintain productive relationships with other people, and to do a good job (Schabracq, 2003). When integrity prevails, the number of stress complaints typically decreases and this is conducive to better work health. Coincidental negative processes, such as organizational underdevelopment, rationalization, downsizing, decay, change, or intrusions by external events, may cause a decline in integrity. Integrity may also be affected by stressors primarily affecting particular tasks and stressors disturbing the immediate task environment (Schabracq & Cooper, 1998; Herzberg *et al.*, 1959). In summary, the decline or absence of integrity may potentially have a negative effect on work health, and thus on organizational health.

Profession

According to Abbott (1988), the concept of a profession is closely connected with the power to define the relevant valid knowledge within a particular field. The monopolization of knowledge is a hallmark of professions, which generally strive to retain their ownership of or

jurisdiction over, specific disciplinary areas. Knowledge and jurisdictional fields, however, are not constant, and can be regularly transformed by wider organizational, technological and institutional changes. They can also be transformed by, or because of societal changes in health and living conditions, for example, through decreases in the social status of health professionals or managers. Professions and professional practice are therefore characterized by continuous reflection, assessment, and adjustment (Squires, 2005).

The concept of a profession can be incorporated into a conceptual framework of organizational health and public health management and leadership for several reasons. Management in personnel-intensive health care organizations is, largely, about the management of professionals. Individuals mostly manage themselves in their working processes, and ambivalence and resistance by professionals towards management may be problematic. To some extent, it could be argued, professionals are 'allergic' to administrative management and control, and may have individual interpretative responses to reforms and corporate change (Stensaker & Falkenberg, 2007). As suggested above, when they are more strongly committed to their own profession than to their work organization, health professionals may challenge both their managers and their employers (Hernes, 1996, 2001).

For health professionals, who have been skilled primarily to take care of individual patients, it may even be hard to understand processes in complex health care organizations, particularly during phases of change (Dahlbom-Hall & Jacobsen, 1999). People's connotations associated with professions and professionals can be both positive and negative. In a Swedish study referred to above, professionals from project teams in a hospital were found to understand the concepts of value based management and healthcare. The study concluded that changes in organizational culture required changes in healthcare – a shift from being professional-centred to being patient-centred (Andersson *et al.*, 2015). However, it should be noted too that human values need to inform both professional-centred and patient-centred health care.

The majority of health care managers are educated as health professionals, and therefore experience pressure from both the values associated with their profession and the values of administrative management. Some managers may also work as clinicians, and may therefore experience significant cross pressures and value turbulences. Growing jurisdictional conflicts between health professionals and administrative managers educated in other disciplines may also challenge effective communication and collaboration in health care services (Nordby, 2009). Additionally, health professionals may feel particularly vulnerable with respect to work health problems (Arman *et al.*, 2012; Hasson, 2006). For these reasons, attention is also given to health professionals during the development of a theoretical framework.

In conclusion, the theoretical framework draws on a dialectical approach, as well as on the concepts of hybrid and value based management, and value conscious and health promoting, servant leadership. The insights which are rooted in these approaches, contributed substantially to the process of developing the preliminary and the revised models of organizational health, in which value tensions and inconsistent logics are reframed by institutional theory. The recognition of the tension between human values and economic values, and the inconsistencies between the values associated with health organizations as health institutions and health enterprises were further key steps in the development of the conceptual model of organizational health, and the exploration of the implications for public health management and leadership.

Chapter 5:
Research design and methods

The description and development of a new conceptual model of organizational health requires a variety of methodological approaches. The research design in this thesis was therefore based on a combination of induction, deduction and abduction. Inductive reasoning was central to the qualitative analysis, but iterative processes linking inductive and deductive approaches were also crucial to the process of conceptualization. In addition to using inductive and deductive reasoning, I also employed abductive reasoning – a free, scientific approach that highlights new ideas and possibilities (Eriksson, 1991; Peirce, 1990). The abductive approach seemed particularly valid to the development of the concept of organizational health, which, so far, has been only rarely described and operationalized within the setting of public health care. While mostly qualitative methods were applied, mixed methods were also used as a way of enabling the collation and use of diverse, potentially relevant data and theoretical perspectives (Morse 2003). Mixed methods, as Johnson (2007) notes, are likely to provide findings and outcomes in relation to specific research questions. During the phases of conceptual analysis, however, qualitative methods were predominant.

A hybrid model of conceptual development has informed the research process in this thesis. In this model, theoretical reflections and empirical findings are to be found alongside each other, and a final synthesis phase is included. This approach has been shown to be useful as a way of elucidating new concepts and attaining a deeper understanding of the problematic and non-problematic consequences of concepts in practice (Rodgers & Knafl, 2000; Lee *et al.*, 2008). The first phase of the research, from which a tentative definition of organizational health emerged, was theoretical. The definition I formulated informed the second, empirical phase. The empirical findings formed the basis of further revisions to the definition of organizational health and contributed to an assessment of its value in the shape of a validated and revised, conceptual model, which is discussed in more detail below.

Reflexivity

A hermeneutical epistemology developed in a scientific tradition is generally the starting point for knowledge development, particularly in concept determination (Eriksson, 2010). The start of the development of a conceptualization of organizational health was informed by a classical hermeneutical approach in which each element of a concept is seen as part of the whole concept, and each element derives its meaning through interpretation in light of the whole. In such a hermeneutical inspired process of conceptualization, reflexivity enables explicit thoughts and experiences about the research theme to emerge through an examination of one's preunderstandings in general and "conceptual baggage" in particular (Kirby and McKenna, 1989).

According to Malterud (2001), basic guidelines for qualitative inquiry should embrace relevance, validity and reflexivity, all of which are important to the process of measuring quality. Malterud describes reflexivity as the process of systematicallly attending to the context of the knowledge construction at every step of the research process, but particularly to the

effect of the researcher. Reflexivity therefore starts, she suggests, through the identification and sharing of preconceptions that are brought into the project by a researcher. The background and position of a researcher affects not only what he or she chooses to investigate, but also the angle of the investigation. As Malterud suggests, researchers' frames of reference will also affect the methods they judge to be most adequate for the research purpose, the findings they view as most appropriate, and the framing and communication of the research conclusions.

As Figure 1 illustrates, reflexivity is an ongoing process in the development of a validated conceptual model, and includes a researcher's reflections on experiences that take place during the research project, as well as those that lie ahead. The figure also draws attention to the importance of consciousness and the sharing of preunderstandings and prejudices which, from a classic hermeneutical understanding, help further in aiding interpretation and understanding (Gadamer, 1999).

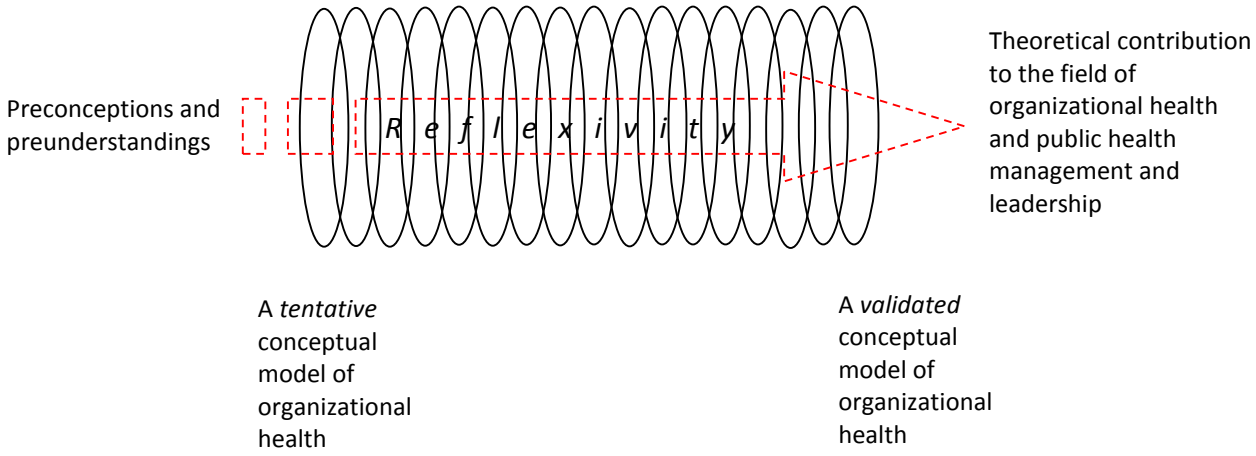

Figure 1

Validation of a conceptual model of organizational health

In addition to facilitating the sharing of preunderstandings, reflexivity is important because it enables reflection. As noted above, my research interest has been influenced by my more than 30 years of experience in teaching nurses and other health professionals. During these years, several newly graduated candidates told me about their experiences during the initial phases of their careers. They also told me how they perceived the tensions between their socialization at nursing schools and the conflicting role expectations experienced in their workplaces. Some characterized these tensions as stressful reality shocks and as work health challenges. Inspired by earlier studies in the field of newly-graduated nurses, and particularly the strategies used in dealing with similar tensions (e.g. Kramer & Schmalenberg, 1977), I therefore introduced a tentative model in a previous paper in which the value clusters of the patients, the service production and the health professionals were integrated (Orvik, 2002). However, these strategies were examined on an individual level. I have therefore looked more widely for textbooks and scientific publications on this topic, and searched for metaphors, concepts and terms of potential relevance to exploring these kinds of tensions and challenges on an

organizational and managerial level. In this regard, the philosophy of health promoting hospitals (e.g. Groene, 2006) seemed appropriate.

My preunderstanding of the field and my interest in this research may also have been influenced by the time working in an interprofessional team early in my career and by the years in management positions in a school of nursing and other health educations. When teaching health professionals in hybrid roles at master courses in health management and leadership, I integrated these experiences into my lessons. Some of these students referred to, and reflected on, the unpleasant and increasingly economic constraints they faced in their management roles. In some cases, they commented on what they perceived to be their own lack of vocabulary for describing the feelings they associated with these 'cross pressures', and such reflections were also integrated in Master's thesis I judged as an external examiner. It is within this context that I have introduced a tentative, conceptual model of organizational health and partially and indirectly tested its relevance to management and leadership in the field of public health care.

During the last few years, I have held a part-time position as an advisor in a Norwegian health promoting hospital. This position has been an essential part of my professional work and coincided with my research in organizational health. It has also been a door opener to interesting, international meetings, and to contact with researchers such as Jürgen Pelikan who has investigated improvements in organizational health and quality in health promoting hospitals (Pelikan *et al.,* 2014). These meetings and contacts, in turn, influenced my research at different stages of the research process. For instance, Pelikan's differentiation between the health *of* an organization and the *health impacts* of an organization on people is a conceptual approach that I have integrated into the revised model of organizational health. Necessarily, as Malterud (2001) suggests, interactions of this nature will affect which findings one considers most appropriate for analysis, as well as how conclusions are framed in publications. While these inspiring encounters obviously influenced the context of the knowledge construction in this thesis, it was also important for me to maintain a critical distance.

In this thesis, the research findings and reports from authorities of an increase in the work health challenges within health care organizations also informed the conceptualization process. These reported increases appeared to coincide with management reforms and political changes: I therefore decided to utilize a postmodern hermeneutical approach inspired by Vattimo (1997). This approach is more than a classical hermeneutical interpretative theory and method (Gadamer, 1999). Instead, postmodern hermeneutics is an integration of hermeneutics and social science, and provides a critical approach to conflicts in postmodern societies (Selander, 2005; Nyström, 2005). Such an approach seemed particularly appropriate to the analysis of underlying competing, institutional logics and conflicting values in – and between – health care organizations. A postmodern hermeneutical approach was particularly useful in the final, synthesizing phase of this thesis, during the integration of critical elements of theoretical and empirical knowledge, and in the refinement and validation of the conceptual model of organizational health.

In keeping with the principle of reflexivity, the methodological reflections and decisions referred to above need also to be examined in terms of my own preunderstandings, and to be made explicit. Certainly, my background in diaconal studies and health sciences may have influenced the research steps I took during the investigation and during my methodological considerations. Both my focus on values and the critical perspective integrated in postmodern hermeneutics can be linked to elements of my professional frame of reference.

I have outlined the importance of reflexivity to the research process above. The importance of trustworthiness and credibility to establishing the rigour of qualitative research is emphasized by Lincoln and Guba (1985), and will be discussed in more detail below**.**

Methods of data collection and inclusion of articles

The five studies included in this thesis all used qualitative or mixed methods. Each was based on the epistemological recognition that qualitative data are influenced by how participants make sense of their experiences within research contexts (Denzin & Lincoln, 1998). While the preliminary, conceptual analysis (Paper I) was based on a literature review, a systematic literature review approach was used in the methodological study (Paper V). The three remaining papers were empirical in nature and based on qualitative interviews and document analysis; one included descriptive statistics and specific statistical tests (Paper III). Health managers participated in each of the three empirical studies, and clinicians and politicians in one of them (Paper III). The methods used for the data collection and the inclusion of articles reflected the inductive, deductive, and abductive approaches described above.

Paper I

The conceptual analysis started with a literature review, which identified relevant empirical and theoretical articles in the following databases: AMED, CINAHL, EMBASE, ISI, MEDLINE, PsycInfo, and Sociological Abstracts. These were searched using topic-specific subject headings and text words such as 'organizational health (promotion)', 'workplace health (promotion)', 'organizational dilemma', 'organizational antagonism', 'health (care) organizations', and 'New Public Management'. Articles published in English or Scandinavian languages from 1999 to 2010 were included. Articles within the field of health care services were prioritized, as were articles within other human service organizations and, to a lesser extent, articles that shed light on general aspects of organizational health. Duplicates were identified and removed in the initial search. The abstracts were then screened and most of the relevant articles were obtained for full text reading.

Paper II

The study participants were ten ward managers in total, from six Norwegian hospitals. The participants were all nurses and were chosen because of their key role with regard to quality issues in hospital wards, including the management of quality reports of improper or unethical patient care and medical treatment. Ward managers were also selected because of their closeness to health professionals and to patient care in hospital clinics. In addition, ward managers were selected because of their closeness to middle- and high-level hospital managers and the increasing focus on efficiency in hospital organizations and health enterprises. To achieve geographical and cultural diversity, the participants were recruited from inpatient and outpatient clinics in three different health regions in Norway. The study was approved by the Norwegian Social Science Data Services, and in accordance with a requirement for informed consent, the participants were given written information about the project and told that they could withdraw from the study at any time and without specifying a reason.

Some of the participants were selected randomly, others purposively and conveniently. The selection of participants with diverse backgrounds was done deliberately to reach a state of data saturation; a sense of closure is obtained when the data yields only redundant information

(Polit & Beck, 2008). All except one of the managers included were women. The sample was, otherwise, a heterogeneous group and included a diverse range of competencies and experiences. In order to identify and explore the widest possible range of relevant issues, the interviewer sought participants with backgrounds from different hospitals, who were familiar with the topic of this study. To some extent, the sampling procedure might therefore be characterized as purposive.

Qualitative interview methods were applied to facilitate deeper reflections, reactions and emotions on sensitive issues. Kvale and Brinkmann (2009) regard the use of qualitative research interview methods as a pragmatic approach in instances in which researchers need to make informed epistemological and methodological choices. Consistent with this approach, the interviews were conducted using an interview guide, but with a reflective and a reflexive approach to the knowledge sought. Closed and open questions were used when researching quality management, reporting routines, and strategies for the implementation of quality standards. In addition, the ward managers were also given the opportunity to comment on research findings in each of the hospitals that had indicated an under-reporting of quality deviations.

All the interviews were performed, recorded and transcribed verbatim by the second author.

Paper III

This study formed part of an evaluation of the experimental organizational design of an intermediate ward for patient treatment at a nursing home in a Norwegian municipality. The management and conduct of the ward was a joint concern of the municipality and the neighbouring hospital. Patients were recruited from medical and surgical wards at the neighbouring hospital two to three weeks before the medical treatment in the hospital was terminated. The purpose of this study was to evaluate the interorganizational collaboration between the municipality and the hospital, and the study included qualitative interviews and an analysis of planning documents, notes and minutes from meetings, reports and statistics. The study also investigated the possible effects on the quality of patient care and the economic efficiency of the project for the organizations involved.

The majority of the participants interviewed during the evaluation of the collaboration were strategically recruited from the hospital and the municipality. These interviews subsequently led to further interviews with additional participants who were selected successively using the so-called ‘snowball’ recruitment technique (Berg, 1983). In total, 31 qualitative interviews were conducted with 28 participants, who either had been involved with or had ties to the intermediate ward. Three of the participants were interviewed twice. The interviewees included nine participants from various clinical departments in the hospital, and three participants from the hospital administration and the hospital board, including one director. Six participants from the intermediate ward, nine participants from the municipality, including three politicians, and one participant from a local university college who had been involved in the establishment of the intermediate ward as an employee at a local health enterprise, were also interviewed. The semi-structured interviews were based on an open-ended interview guide and conducted as informal talks with the participants. The third and the fourth authors participated in each interview and took notes.

The effects on the quality of care were assessed in a retrospective and a prospective study. The retrospective study was conducted by means of a postal questionnaire sent to patients who had

stayed at the intermediate ward. They were asked about their satisfaction with the care received and about where they had been discharged to and their needs for municipal care when they returned to their homes. The questionnaire was developed and validated by the Norwegian Knowledge Centre for the Health Services, but for the purpose of this study, some adjustments of the questions were necessary. The prospective study was conducted by following a quasi-experimental research design, where a study group of patients who had been transferred from the hospital to the intermediate ward was compared with a control group of similar patients at the hospital. The patients in the two groups were compared using a similar questionnaire as in the retrospective study.

The economic effects were studied mainly through an analysis of the length of stay and the average costs per patient per day at the intermediate ward. The results were compared to the average costs per patient per day in the clinical hospital departments. These analyses were based on financial reports and official statistics from the municipality and the health enterprise.

Paper IV

The starting point of this study was a project associated with the relocation of an old, traditional university hospital to a new, high-technology hospital organization in Norway (Berg, 2012). The methodological approach used in this project was trailing research. In this participant-oriented form of evaluation, researchers follow a process or a programme from beginning to end. It is an approach requiring less research intervention compared to more action-oriented research methods (Reason & Bradbury, 2001). The central idea underlying the trailing research method is that it combines the evaluation activities and processes of reflection, and enhances the immediate use of evaluation findings through formative and summative activities (Finne *et al.*, 1995). By integrating formative and summative elements, trailing research includes the learning processes of organizations within the construction of scientific knowledge. In this study, the researchers reflected on the research process together with the participants, and also reported the results to them in a limited way, and made few interventions in the research processes. A centre for health promotion at the university hospital studied initiated the project, which was approved by the hospital director and The Data Protection Official for Research at the university hospital.

The aim of the part of the study referred to in Paper IV was to collect data on the experiences of managers and professionals prior to a hospital relocation and the associated transformations taking place in the work organization. Data were collected using qualitative interviews and from planning documents. Fourteen participants were recruited and one of them was interviewed twice. The participants included two current and four former hospital directors, seven clinical managers, and one personnel safety representative. All but one of the hospital directors were health professionals, and the safety representative was also a health professional. Four clinical managers were in first-line management positions and three were in second-line positions. Half of the participants were recruited via written and verbal invitations, while the study researchers made selective inquiries to recruit others participants. In keeping with the requirements of informed consent procedures, the participants were told that they could withdraw from the study without providing a reason, and declarations of consent were signed before the data collection started.

Qualitative interviews were conducted to capture the unique circumstances of each participant, and to allow for a closer examination, through interactions between researchers and interviewees, of particular responses to sensitive topics (Kvale & Brinkmann, 2009). The

interviews were conducted from October 2007 to August 2008. Two researchers, namely the first author and a colleague experienced as a qualitative researcher and as a physician, interviewed each participant, and the colleague transcribed the audio recordings verbatim.

Paper V

In the trailing project mentioned above, of which Paper IV was a part, multiple methods of data collection were used, including focus group discussions. These discussions led to reflections and debates among the research colleagues about the significance of the contextual factors that were potentially affecting the analysis of the focus group results, and to related epistemological and methodological questions. Should, for example, the personal backgrounds of the participants be noted, such as their age and gender, or their professional and work experience? How should the process data related to group interactions and the moderators' involvement be integrated into the analysis of the focus group data? A decision was taken, together with other experienced research colleagues, to scrutinize more thoroughly the impact of the situational factors involved. Our reflections on this process formed the starting point for Paper V.

In this methodological study, a systematic literature review (Melnyk & Fineout-Overholt, 2011; Hart, 1998) was conducted. The first step involved collecting information on how issues related to the context of focus group methodologies were expressed and analysed in articles reporting on data collected in focus group discussions. To differentiate between data gathered during focus group discussions and data gathered by other methods, we narrowed the scope for inclusion to articles reporting on focus group discussions as the *only* data collection method. The following topics were additional criteria for the inclusion of articles: workplace health, stress, and coping among health professionals. These criteria were chosen based on their relevance to the field of work health and organizational health.

Focus group discussions have been characterized as an appropriate method for evaluating attitudes, knowledge, and experiences within the field of health care (Barbour & Kitzinger, 1997; Blythe *et al.*, 2001; Berland *et al.*, 2008). This method is characterized by carefully planned discussions, and places emphasis on the importance of making group processes and interactions visible. Focus group dynamics can be characterized as an extension of individual interviews, and can be used to clarify views that might otherwise be less accessible or evident in such interviews (Morgan & Krueger, 1998).

In this study, articles were gathered from the MEDLINE, EMBASE, and CINAHL databases. We searched for articles covering the period January 2004 to February 2009, by using topic-specific subject headings. 481 articles were identified in the initial search and duplicates identified; 55 articles were retrieved and read in full text. Ten articles were then selected for further analysis. To strengthen the validity of the findings, two authors read the articles independently. The study included an assessment of how the methodological reporting of contextual factors might have influenced and improved the quality and the trustworthiness of the articles.

Methods of analysis

Different methods of analysis are required when preparing theoretical, empirical and methodological papers. The data for this thesis were collected using a variety of methods and in different settings. However, a combination of qualitative content analysis (Graneheim &

Lundman, 2004; Polit & Beck, 2008) and template analysis (King *et al.*, 2002; King, 2004) was used in the majority of the papers.

Paper I

The paper included an analysis of theoretical and empirical research predominantly in the fields of work health and health management, as well as research on health care services and professional organizations. The development of a conceptual model of organizational health was inspired primarily by the need for such a concept in the Nordic context. However, research set in Nordic countries as well as other international research was included in the analysis.

Most of the relevant full text articles were reread and analysed with regard to the identification of work health issues in health care organizations, with specific attention given to organizational health or analogous concepts. This enabled the construction of an overview of the relevant conceptual developments undertaken by researchers thus far and provided ideas for further conceptual development of organizational health, through both abductive and iterative reasoning. This study therefore gradually became a platform for the development of an initial, conceptual model, but also for an analysis of the different dimensions of organizational health, and the conceptual model as a whole. This also formed a starting point for the analysis of the implications of organizational health for public health management and leadership.

Paper II

In the qualitative content analysis in this study, the transcribed data were divided into meaningful units and collated using coded themes (Graneheim & Lundman, 2004). This enabled broad and overriding themes to emerge, and the data were transformed from the descriptive level to an interpretative level. Key themes were then contextualized within the particular setting in which the data had been gathered as a way of elucidating and discovering whether the interpretations of the data were contraindicated.

In qualitative content analysis, categories are generally exhaustive, mutually exclusive, and do not overlap (Graneheim & Lundman, 2004). In this study, applying this approach to categorization was particularly challenging as the content analysis was combined with a template model for the organization and interpretation of qualitative data (Crabtree & Miller, 1999; King, 2004; Polit & Beck, 2008). Template analysis is characterized by the specification of an *a priori* number of themes that are especially salient to a research project (King *et al.*, 2002). The purpose of the template is to reduce the amount of data being considered, by bringing together related pieces of text earlier in the analytical process, and facilitating the identification of possible connections between data (Crabtree & Miller, 1999). This more flexible approach allows modifications to be made to the themes relevant to the needs of specific studies. The disadvantage of this methodological approach is that the templates may be too simple to allow for deep interpretation or, more often, may be too complex to be manageable (King, 2004).

In general, coding lists can be modified and some items deleted in the process of ongoing analysis (King, 2004). Coding lists can therefore be used to refine a concept, as data are interpreted (Malterud, 2001; Polit & Beck, 2008). In this study, three dimensions of integrity were used to establish the *a priori* list of codes; the code manual was slightly adjusted because

of this approach and the interpretation of data. Thus, the template analysis effectively became a test of the validity of a concept that had been tentatively operationalized using a specific code manual.

Content analysis and template analysis were combined in a six-step analysis model; (i) central units of meaning were identified; (ii) data were condensed – as far as possible – without changing the original meaning; (iii) the condensed units of meaning were labelled with a code stating their content; (iv) subcategories were created using codes; (v) the subcategories were then sorted according to the code manual; and (vi) units of meaning with relevance across or beyond the code manual were integrated, so as to modify or delete elements in the manual. In this study, units of meaning with relevance across or beyond the code manual were named integrative themes – an idea inspired by King and colleagues (2002).

Paper III

Field notes taken by the two researchers involved in each of the qualitative interviews were compiled and analysed, and their impressions and interpretations were matched against each other and compared. This enabled a form of comparative content analysis in which the themes of the interviews were illuminated through the different perspectives and assumptions of the two researchers. This process also helped to provide a form of validation of the qualitative interview results (Kvale, 1996; Kvale & Brinkmann, 2009). Mixed methods were used to supplement the analysis, including a content analysis of planning documents, and the use of an analysis of descriptive statistics and statistical tests related to patient satisfaction, flows and costs.

In this study, content analysis was combined with elements of template analysis. After analysing the processes between the collaborating partners, the effects of such collaboration on quality of care and economic efficiency were analysed. The selection of themes was based on two of the three key concepts in the revised conceptual model of organizational health. The analysis of collaboration, quality and efficiency also induced an examination of issues of trust and integrity, which were regarded as an integrative theme in the analysis of this paper. The results from the retrospective study of patients' experiences were analysed using descriptive statistics; for the prospective study, statistical tests were mostly used.

Paper IV

Data were collected during qualitative interviews with clinical managers as well as current and former high-level managers in the university hospital. These were analysed using content analysis and template analysis. This combined approach was particularly pertinent to the purpose of this thesis, namely to develop and validate a conceptual model of organizational health. The starting point of the template analysis was the development of a coding list for the three core values that had emerged thus far during the conceptualization of organizational health, namely: quality, efficiency, and integrity. These were perceived to be nodal values, each belonging to the three value clusters of patients, production and professionals which formed the key elements of the tentative conceptual model of organizational health described in Paper I. As noted above, nodal values refer to values that have a large number of related values (Jørgensen, 2006).

The first analysis of the qualitative data focused on issues related to the two nodal values of quality and efficiency, while issues related to the third nodal value – integrity – emerged as the

analytical process continued. The emergence of the three nodal values as coding list elements during the analysis justified the use of a combination of both template and a content analysis in this study. From a postmodern hermeneutical perspective, this process contributed to a critical reflection on the interrelations and tensions between the three core concepts, and thus to the validation of the conceptual model of organizational health.

In addition to the use of content analysis and template analysis, elements of a reflective method were used as a third strategy of analysis, both in the interviews as well as the analysis after the interviews. This critical, reflective approach to the values of professional practice and management sees values as a key to comprehending established patterns of action and behaviour. According to Aadland (2010), the use of organizational members as co-researchers of their own value constructions within specific contexts is recommended. This method, too, is in keeping with a postmodern, hermeneutical perspective, and was especially appropriate to an assessment of the radical change, which was taking place in a complex and personnel-intensive hospital organization.

Paper V

The analysis of the ten articles selected for the evaluation of contextual factors in focus group discussions occurred in four stages. First, all ten articles were read by the first three authors, who independently assessed the methodological quality of each paper according to the criteria developed by Malterud (2001). In the second stage, the articles were re-read, and each occurrence of explicit references to the six situational factors was noted. At this stage of the analysis, no evaluation of the issues was undertaken. The third stage involved the analysis of the meaning of the text in each of the articles in three selected sections: the methods section, the results section, and the discussion. The analysis included findings related both explicitly and implicitly to specific contextual factors in the analytical framework, as well as contextual findings of relevance across and beyond this framework, in instances when these had potential methodological relevance for the focus group discussions. Thereafter, the ten article texts were analysed using a combination of qualitative content analysis (Graneheim & Lundman, 2004; Polit & Beck, 2008) and template analysis (King, 2004; King *et al.*, 2002). In this combined analysis, the texts were condensed into six steps that were designed to preserve the core content. This process was in keeping with the processes described in Paper II.

These analytical steps included an assessment of how the methodological reporting of contextual factors might have influenced and improved the trustworthiness of the ten articles. Supplementary mixed methods were used, in which quantitative elements were incorporated. An analysis was made, for example, of the frequency of the six situational factors in the method section, the result section, and the discussion of each article.

Why and how should a methodological study of focus group discussions be included in a thesis on the conceptualization of organizational health? In short, the articles and the analysis of the articles covered substantial, methodological and epistemological topics relevant to the conceptualization of organizational health in this thesis. The focus on issues of workplace health, stress and coping among health professionals relates directly to the essence of organizational health. The analysis of contextual factors, using a combination of content and template analysis, contributed further to deepening the understanding of both the analytical process, and the process of conceptual development as a whole. Epistemological reflections on the concept of contextual (i.e. situational) factors, which were relevant to the conceptualization of organizational health, are detailed below. Finally, the contextualization of the focus group findings is consistent with a hermeneutical approach to data analysis, and is in keeping with

the contextualization of work health to organizational values which underpins this thesis. It is also consistent with the integration of traditional hermeneutics and social sciences into postmodern hermeneutics, and with critical approaches to value conflicts in postmodern organizations (cf. Selander, 2005; Vattimo, 1997).

The methods of data collection and inclusion of articles and the methods for analysis are summed up in Table 1. For the purpose of maintaining logical coherence, the five papers are presented and discussed in a non-chronological order. The tentative model introduced in Paper I formed the starting point of this work, and led to the three empirical papers as a result of illustrating the potential links of the phenomenon of organizational health to clinical and managerial settings. Paper I also inspired the use of template analysis models in the empirical papers, in which key concepts of the organizational health model formed an *a priori* number of themes that were particularly salient to my research project.

The findings in Paper V refer mainly to the final, synthesizing phase, although this methodological paper was published before the empirical ones. Like Paper I, the findings from Paper V also inspired the use of template analysis in the empirical papers. Paper V, in particular, contributed to epistemological discussions related to the development of the conceptual model of organizational health. Thus, the sequencing of the papers is in keeping with the principles of the hybrid model referred to above (Rodgers & Knafl, 2000; Lee *et al.*, 2008), in which theoretical reflections are supported by empirical findings, and are presented with a final, synthesizing phase of conceptualization.

Table 1

Overview of the methods of data collection, inclusion of research articles, and analysis of the results

Paper	Methods of data collection and inclusion of research articles			Methods of analysis
	Sample	**Setting**	**Method**	
I	Research articles in the field of organizational health, work/workplace health, organizational dilemmas, organizational antagonism, health care organizations, New Public Management	Health management and health care organizations, human service organizations, other professional organizations	Literature review	Theoretical analysis, conceptual analysis
II	Random, purposive, convenience	Hospitals ward managers	Qualitative interviews	Content analysis, template analysis,
III	Strategic, snowballing	Managers in the hospital and the municipality, nurses and physicians in a hospital department and a municipal, intermediate ward, a member of the hospital board, politicians and a participant from a local university college	A mixed methods design Qualitative interviews, analysis of documents	Comparative content analysis, template analysis, statistical analysis
	Retrospective and prospective	Patients who had stayed at the intermediate ward and a similar group of patients at the hospital	Questionnaires	Statistical analysis and tests
IV	Purposive, convenience, snowballing	Top managers and clinical managers in a university hospital in radical organizational change	Qualitative interviews, analysis of documents	Content analysis, template analysis, critical reflective methodology
V	Research articles using focus group discussion as the only method	The field of workplace health, stress and coping among health professionals	Systematic review A mixed methods design	Content analysis, template analysis, conceptual analysis

Rigour and trustworthiness

Three of the papers in this thesis use qualitative methods and the remaining two are qualitative studies supplemented by mixed methods. Standards for assessing the quality of qualitative research are therefore relevant. The concepts of reliability and validity, which respectively refer to the handling of data and to whether a study investigates what it intends to investigate, are also applicable to qualitative research (Kvale, 1996; Kvale & Brinkmann, 2009). However, according to Malterud (2001), basic guidelines for qualitative inquiry should embrace relevance, validity and reflexivity. While relevance and validity are essential, reflexivity is an equally important measure for quality, as noted above.

In each of the papers, and at different stages of the research process, efforts were made to attend systematically to the context of knowledge construction. For example, in Paper II, the condensing and categorization of the units of meaning were thoroughly discussed by the researchers. In Paper III, the interpretation of the field notes taken by each of the researchers during the qualitative interviews was compared afterwards and this helped to validate the interview results. In Paper V, each of the articles selected was initially read by the first three authors, and thereafter re-read independently by two researchers. The processes of condensing and categorization were also discussed with the two other researchers.

According to Lincoln and Guba (1985), the concept of trustworthiness is essential to assessing and verifying the rigour of qualitative research; credibility, they argue, is particularly important in establishing trustworthiness. In the data collection and analysis phases of this research, the process of ensuring the trustworthiness of the findings was a key focus. In the analysis of Paper III, the two researchers who performed the interviews regularly discussed their different impressions and interpretations together. In Papers II and V, the researchers also discussed the results frequently. To enhance the rigour of the analysis in Paper V, detailed decision trails of the analytical steps were produced in which clear and mutually agreed data related to the process of analysis were described. Decision trails were also used in the data analysis in Paper IV, which was discussed with the other researcher involved in the data collection. Such decision trails allow for an overview of the interpretations and thereby strengthen the reflexivity of the research findings (Clarke, 1999; Whitehead, 2007; Selamat & Hashim, 2008).

The issue of trustworthiness will be deepened in the methodological discussion below.

Ethical considerations

The aim of research is to solve practical problems and to contribute to the improvement of the quality of life of individual participants – as well as those outside the research process – and to the development of organizations and society as a whole. The development of knowledge, and thereby the elimination of ignorance, as Resnik (1998) suggests, is also a search for truth: this quest must be the ethical norm and the epistemological goal of research. Ethical considerations in the research process should therefore start with a general reflection on basic ethical standards, and their roots in morality and science. As research has social implications, ethical dilemmas that may arise in the research process or in the results of the research, should therefore be considered (Resnik, 1998).

Research in health care organizations places particular ethical demands upon researchers who must be aware of the need for honesty, openness and respect. Such ethical imperatives are common to all health services research regardless of the methodological approaches applied. However, some ethical considerations have been identified as being particularly important to the assessment of specific methods – especially, for example, the need to demonstrate beneficence and non-maleficence, fidelity, justice, veracity and confidentiality in qualitative research interviews (Parahoo, 1997; Dreyer, 2012). All these concerns were relevant to the research reported in Papers II, III and IV. To increase the researchers' awareness of ethical issues, general guidelines for assessing qualitative research were also applied.

Inspired by a feminist-oriented ethics of care, Edwards and Mauhner (2002) emphasize that ethics relate to dealing with conflict, disagreement and ambivalence, and that a feminist ethics of care can be especially helpful to researchers in illuminating the sources of ethical dilemmas. They present nine questions, which can be used as guidelines for ethical research practice (p. 27-30):

- *Who are the people involved in and affected by the ethical dilemma raised in the research?*
- *What is the context for the dilemma in terms of the specific topic of the research and the issues it raises for those involved, personally and socially?*
- *What are the specific social and personal locations of the people involved in relation to each other?*
- *What are the needs of those involved and how are they interrelated?*
- *With whom am I identifying, who am I posing as other, and why?*
- *What is the balance of personal and social power between those involved?*
- *How will those involved understand our actions and are these in balance with our judgment about our own practice?*
- *How can we best communicate the ethical dilemmas to those involved, give them room to raise their views, and negotiate with and between them?*
- *How will our actions affect relationships between the people involved?*

These guidelines were relevant to the empirical papers, which also identified organizational factors that may have been sources of ethical dilemmas for the participants and for the researchers. In Paper IV, some of the clinical managers in the university hospital context felt that reorganization and staffing cuts had weakened the quality of patient care, as well as the work environment and work health of clinicians and managers. Some clinical managers disagreed deeply with the changes but had little power to influence them. However, they were required to defend the reorganization and the cutbacks to their patients and patients' families, and to the clinicians because of their closeness as managers to the clinic, and their loyalty to the hospital organization and top-level managers.

In such cases, professionals and clinical managers had found themselves faced with value squeezes. Occasionally, the trailing research itself helped to lessen their burdens because the researcher interviews brought a focus to the caring and empowerment of professionals and managers during these periods of radical change. In Paper II, it was recognised that the moral dilemmas and value squeezes might have been intensified because of the issues covered in the interviews. Such dilemmas may have been heightened for the participants because of the conflicting roles they occupied, both as professionals and as managers.

Managerial and professional dilemmas can become wider ethical and research ethical dilemmas. The ethical dilemmas faced by the researchers were intensified in some instances, such as when they were informed by the participants about matters that could potentially endanger the health and safety of patients. Normally, these ought to have been reported to top-

level managers or to the relevant competent authorities. However, in the research for Paper IV, the relationship of trust established between the researchers and the participants might have been challenged if such findings had been reported. For the researchers, such dilemmas can be further accentuated in cases of multistage forms of research design, in which some of the participants were interviewed at different stages.

In the study reported in Paper III, clinical managers in hospital departments claimed that the personnel at the intermediate ward were unqualified to take care of shared patients. These and similar suggestions may have influenced the balance of professional and personal power between the collaborating partners.

Data from the health professionals, managers and other participants for the empirical papers was undertaken with the permission of the Data Protection Official for Research and the Norwegian Social Science Data Services. The collection of quantitative data from patients in Paper III was undertaken with the permission of the Regional Committee for Medical and Health Research Ethics. In accordance with these requirements, the study participants were given information about the study, both orally and written, and a declaration of consent was signed before the data collection started. The participants were also informed that they could withdraw from the study at any time without giving any reason, that all the data collected would be handled safely and confidentially, and that no identifying information would be used in written publications. By following these procedures, the researchers met the general ethical demands of health services research, as well as the particular ethical demands placed on researchers who collect and use patient data.

Chapter 6:
Findings

The five articles included in this thesis contributed to the substance of the conceptual model of organizational health, but also to the *process* of conceptualization and to the validation, as will be shown below. The process itself was seen as being part of the results, and this idea is reflected in the title, 'Conceptualizing Organizational Health'. Some of the articles aimed specifically to answer the first research question, namely how organizational health in health care organizations can be developed from a public health perspective. Others have also contributed to answering the second research question, which is focused on the implications for public health management and leadership.

Paper I

Until recently, few studies have described organizational health in health care organizations. Although the concept has been used in the management literature, it has seldom been operationalized in health care contexts. In this conceptual study, the aim was primarily to develop this nascent concept further and, at the same time, to explore the issue in terms of its management implications. In Paper I, the term 'organizational health' was tentatively defined as how well an organization is able to cope with the tensions of diverse values in ways that are of benefit to the patients, the professionals, and the organization as a whole.

This preliminary definition suggests that when developing such a concept, health care organizations must be assessed according to their concerns related to patients, health professionals, and the production of health services. These concerns constitute what could be termed different 'value pyramids', which may vary depending on the particular priorities of the organizations and trends in their environments and organizational fields. In principle, these diverse value pyramids may all be compatible with organizational health.

One of the main findings of this study, however, is that the concept of organizational health should be primarily influenced by the notion of an inverse value pyramid – one in which patients and professionals are the most important elements. This means that the health of patients and the work health of professionals must be seen as interlinked and that both must be considered jointly by health care organizations. It also suggests that preoccupations about efficiency of production should be regarded more as a *constraint* for the promotion of organizational health.

New Public Management has had potentially negative effects on the quality of patient care as well as the integrity and work health of professionals. An inverse value pyramid is therefore judged to be particularly important to the recruitment and retention of professionals in health care services, because it focuses attention on their competencies, integrity and work health. However, as noted in Figure 2, both organizational efficiency and organizational health can contribute to the overall organizational effectiveness.

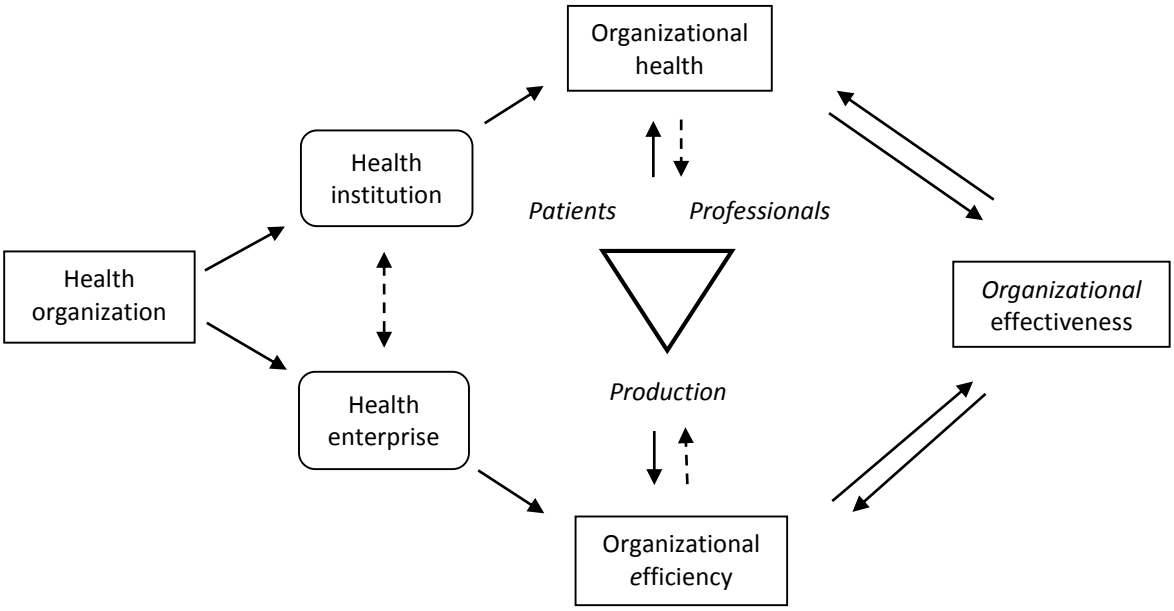

Figure 2

A preliminary model of organizational health

Organizational health in health care organizations requires managers to handle and reflect upon contradictory logics and competing values. Managers must identify and interpret these diverse logics and values, but also develop strategies for dealing with value tensions in ways that are healthy for them as well as for organizations as a whole. This paper proposes that hybrid and value based forms of management and leadership – connected with the integration or disintegration of values and value conflicts – are useful in this regard. The integration of competing values may be achieved through dialogue, and this process may help to strengthen organizational health. However, value tensions may cease, depending on particular circumstances. Organizational health may therefore also be promoted through a process of positive disintegration in which competing values are encouraged, and tensions are maintained in the organization, for example in the form of appropriate resistance to change.

Paper II

This study focuses on the value squeezes and integrity pressures related to the management of quality deviations in hospitals. The paper highlights how ward managers are placed under pressure by organizational dilemmas, especially the value tensions associated with ensuring both quality and efficiency. Tensions associated with the management of quality deviations can challenge the integrity of managers, as well as professional colleagues. This paper identifies different kinds of integrity pressures experienced by ward managers, related to both the values and actions of the managers, and the way in which they are connected to and integrated within, their professional, managerial and organizational environments.

Based on the findings, three strategies for coping with integrity pressures are outlined, and the possible implications for work health and wellbeing are examined. *Quality-conscious* or *efficiency-adjusting* strategies were found to have some negative effects on managers and on organizations as a whole. In contrast, a *hybrid strategy* in which managers seek to balance the demands of quality and efficiency may be more sustainable and health promoting.

These findings suggested that there is a link between the concept of integrity and the substance of organizational health. The incorporation of the work health concerns of health managers into a broader understanding of organizational health formed the next step in developing the preliminary definition of organizational health presented in Paper I, which had focused on the work health of health professionals. Further, the incorporation of the work health concerns of health managers pointed to how the definition of organizational health could be refined through the recognition that organizational health necessarily relates to the health impacts affecting *all* people within or affiliated to health care organizations, including the managers. Finally, it was noted that the identification of a hybrid management strategy for coping with integrity pressures seemed to be sustainable for work health and organizational health. This paper therefore contributed to the elucidation of both the research questions posed in the thesis.

Paper III

The study aimed to evaluate the collaboration between a municipality and a hospital on an intermediate ward project in a nursing home. This unit was a joint concern for both the collaborating organizations. The results indicated that the collaboration between the municipality and the hospital functioned well on a managerial level. However, the relationships between the professionals in the hospital departments who sent patients to the intermediate ward and the professionals in the ward were found not to be optimal. Despite the apparent lack of trust, there were also indications of mutual routine adjustments and improved collaboration. The evaluation indicated that the continuation of the intermediate unit was preferable for reasons of costs and efficiency, as well as the overall benefits of organizational and societal effectiveness.

Three key observations in this study were particularly relevant to the conceptualization of organizational health. First, interprofessional and interorganizational collaboration should be seen as elements affecting organizational health. Doing so may help to expand how organizational health is understood, both empirically and theoretically, and suggests that dimensions of *inter*organizational health may need to form part of this understanding. This latter element has the potential to develop further the conceptual model of organizational health, and is discussed below. Issues of interprofessional and interorganizational collaboration must also be considered with regard to efficiency and effectiveness. In this study, the continuation of the intermediate ward may have been cost efficient for the hospital and the municipality; the overall social effectiveness of doing so was also positive. Tensions between efficiency and effectiveness, as the paper showed, revealed that hospital organizations and municipal nursing homes could be understood as being both economic enterprises and human institutions. In this context, the paper also contributed to revealing how patients and their experiences of the quality of the care provided, constitute a dimension of organizational health.

This paper contributed primarily to the development of the conceptualization of organizational health, but also to deeper insights related to the second research question.

Paper IV

This paper focused on hospital managers and their value orientations, and examined the value tensions associated with radical organizational change at a university hospital. Units of meaning were coded in fourteen subcategories of quality and efficiency, while an 'integrity' category was added as the analysis proceeded. The research explored the strategies used by hospital managers when dealing with competing logics and value tensions, and showed that top managers and clinical managers had different perspectives and strategies, which were dependent on their positions in the organization.

The findings indicated that there was a decline in the quality of patient care ahead of the hospital relocation, and that this may have undermined the hospital's reputation. This, despite the fact that quality concerns were central to both clinical and top-level managers, and patient-oriented ethics and values were seen as key to the 'brand' of the new hospital. Some of the top-level managers saw increased cooperation between the hospital and the primary health care services as a condition for fulfilling these objectives. Some top-level managers also noted that it was expected that the quality improvements would result in resource savings. In this context, one manager referred to 'quality assured efficiency' – a term which reflected the implicit balancing of values and value tensions. However, the inconsistent logics that were potentially embedded in this term were not explained or explored by this manager or others during the course of the study.

Several clinical managers were passionately engaged with quality-related issues. However, they feared that the new ways of organizing clinical work at the new hospital might weaken the follow-up of patients, and suggested that the new hospital had been designed not from a quality perspective, but from an economic perspective. According to some clinical managers, efficiency was the 'real' value that had been influencing the hospital organization. This focus on finances was reflected in the increasing number of requests expressed by politicians and top-level managers both for savings in the hospital and for higher hospital revenues generated. While the top managers involved were reminding clinical departments and managers about the financial concerns, the economists involved were introducing cost-reduction plans and intervening in the clinical domains – much to the surprise of clinical managers. Additionally, the central authorities intensified the focus on efficiency by instructing those in top management to reduce the size of the new hospital by 20% and to finance another 20% of the building costs through efficiency improvements and the use of new technology. The clinical managers in this study acknowledged the legitimacy of both productivity and efficiency concerns, though some feared that the efficiency concerns could be detrimental to quality.

Complex processes and multiple change were transforming the study hospital. Top-level and clinical managers were concerned about the impacts of these on clinicians as respected specialists, about their professional colleagues within the new working environment, and about how to ensure the integrity of those involved. In some cases, the integrity of the clinicians appeared to have been unaffected as perceived by the managers. In other instances, integrity pressures and negative stresses appeared to have influenced the work health and wellbeing of both the clinicians and the clinical managers. These managers reported cross-directional pressures and transformations of their management roles which they indicated had become increasingly affected by value squeezes. Some claimed that the organization had changed from a bottom-up management structure, which respected the professional knowledge and the passionate service innovations, to a top-down structure. While clinical managers had previously primarily been perceived as representatives of the clinical level and of employees,

expectations about their roles had gradually shifted towards being seen as representatives of their employers. Some clinical managers described experiencing a sense of meaningfulness which was, at the same time, accompanied by an increasing sense of discouragement.

The issue of sustainability emerged during the interviews and data analysis, and this suggested that it should be included in a revised model of organizational health. Other findings in this study about the core values and value tensions related to themes such as collaboration, technology, and the organization of health personnel. These, too, contributed to the substance of the revised model. At the same time, aspects of the template analysis strategy used in this study helped to enrich the process of conceptualizing organizational health.

Paper V

This methodological study of how contextual factors can influence the analysis of focus group results was prompted by an epistemological discussion during the trailing research project, of which Paper IV formed a part. The epistemological premises were that qualitative data are influenced by how people make sense of experiences within research contexts, and that data, from a constructivist point of view, are created in – and through – processes involved in the construction of meaning. One finding from this study is of particular interest with respect to its relevance to the conceptualization of organizational health: contextualization in the form of a consideration of situational factors provides rich data for analysis. Such a contextualization is in keeping with hermeneutical perspectives in general. It also indicates the value of using organizational health as a way of contextualizing work health, and as a means of broadening the understanding of issues of work health and wellbeing within the context of health care organizations and their environments and organizational fields.

Another important finding in this study was that the concept of 'situational factors' could be regarded as a sensitizing one – in other words, that it could help researchers to maintain an open and continual process of analytical interpretation and modification, during their attempts to develop deeper understandings of the substance of the concept. Similarly, organizational health itself may also be characterized as a sensitizing concept, as will be examined in more detail in the discussion below. This study also demonstrated the comprehensive, methodological value of template analysis and its contribution to the process of conceptualization. The paper added considerable epistemological and methodological knowledge to the development of a conceptual model of organizational health, and will aid future studies.

Findings in the light of the two research questions

The five studies that form part of this thesis contributed to the grounding and validation of the conceptual model of organizational health. They also formed a useful pathway to the formulation of answers to the first research question, namely how organizational health in health care organizations can be developed in terms of a public health perspective. By focusing on strategies used by health professionals and managers to cope with value conflicts, some of the studies also contributed to gaining insights related to the second research question, namely the possible implications of organizational health for public health management and leadership.

However, a crucial question at this stage is whether the implications associated with hybridization and hybrid management and other forms of balancing and integrative strategies

are sufficiently understood, especially given that these approaches are so openly criticized in research literature. Is hybrid management, for example, a prerequisite for – or an implication of – organizational health? Figure 3 summarizes how the results from the five papers contributed to answering the two key research questions in this thesis.

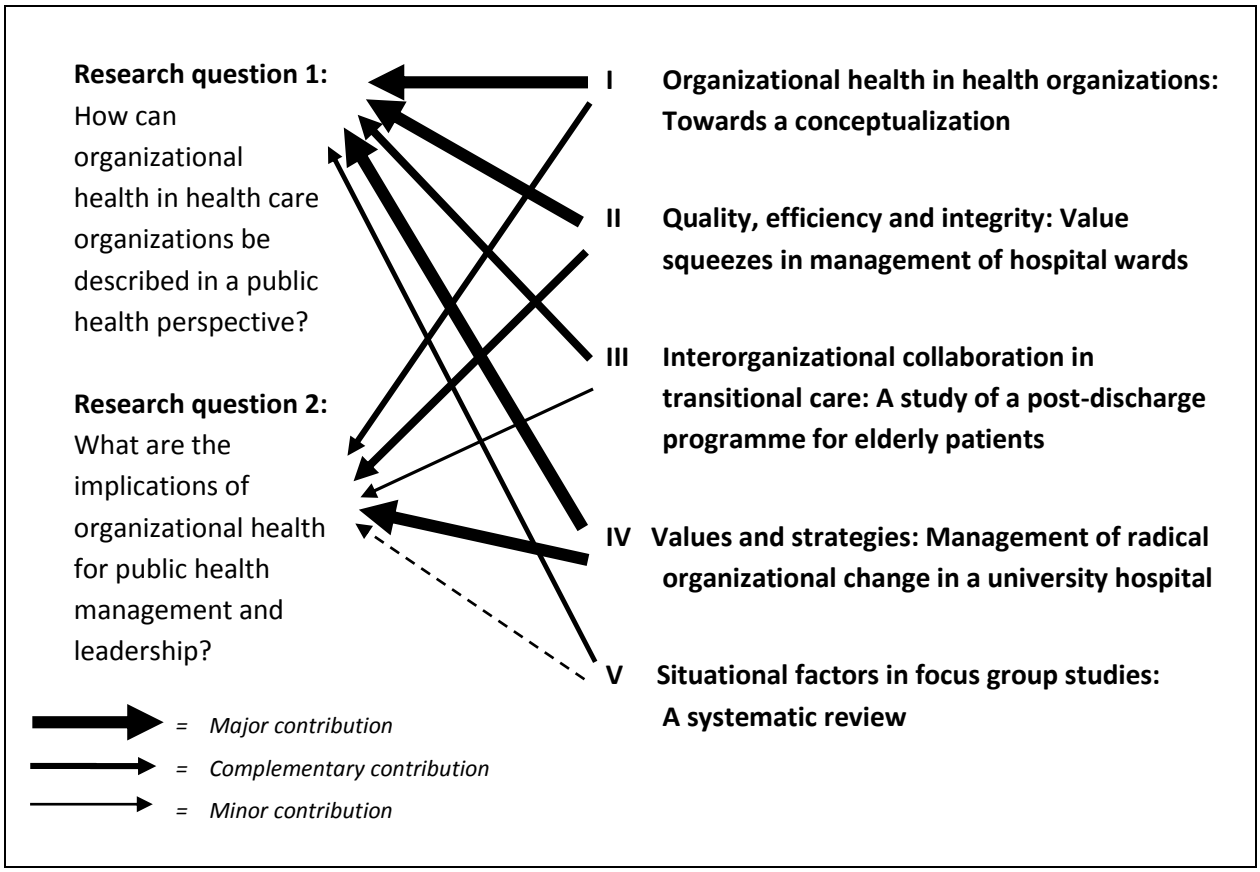

Figure 3

The connections between the two research questions and the findings in the five papers

The research questions now form the underlying structure of the next parts of this thesis. I will discuss these in terms of the findings of the five studies, and draw on key theories within the field of public health, health services research, health management and leadership, as well as institutional theory.

Chapter 7:
General discussion

The starting point of this discussion section is an overview of the revised model of organizational health. Thereafter, possible connections between organizational health, management and leadership will be presented in relation to the two research questions.

Dimensions of a revised conceptual model of organizational health

Paper I introduced a tentative model of organizational health in Figure 2. While organizational effectiveness formed the main goals and focus of this tentative model, a dimension of societal effectiveness is integrated in the revised model presented in Figure 4. This latter model has one crucial modification: public health and sustainability are seen as overarching. This modification influences the fundamental substance of the model and, if this adjusted model is applied, this change in emphasis could influence the mission and vision of health care organizations, management and leadership.

The conceptual model of organizational health introduced in Paper I began with a description and classification of health care organizations as health institutions and health enterprises whose main concerns are, respectively for patients and health professionals, and the efficient production of health services. Working from this starting point and recognizing the link between sustainability and public health, and the integrity and work health of professionals and managers, these elements became central components in the next step of the conceptualization, as well as quality and efficiency. While the tentative model related primarily to health care organizations, the revised model, which include these additional key elements, may also be applicable to other types of human service organizations, such as social care, welfare and educational organizations.

As noted in the presentation of findings in Paper III, interprofessional and interorganizational collaboration point to the importance of recognizing that interorganizational dimensions are also components of organizational health. This is reflected in the relationships described in Figure 4. The figure also illustrates the different implications of organizational health on management and leadership, which are also suggested in Paper I, II and IV – particularly the implications of hybrid management and refinements of value based management. These will be elaborated on later in this thesis.

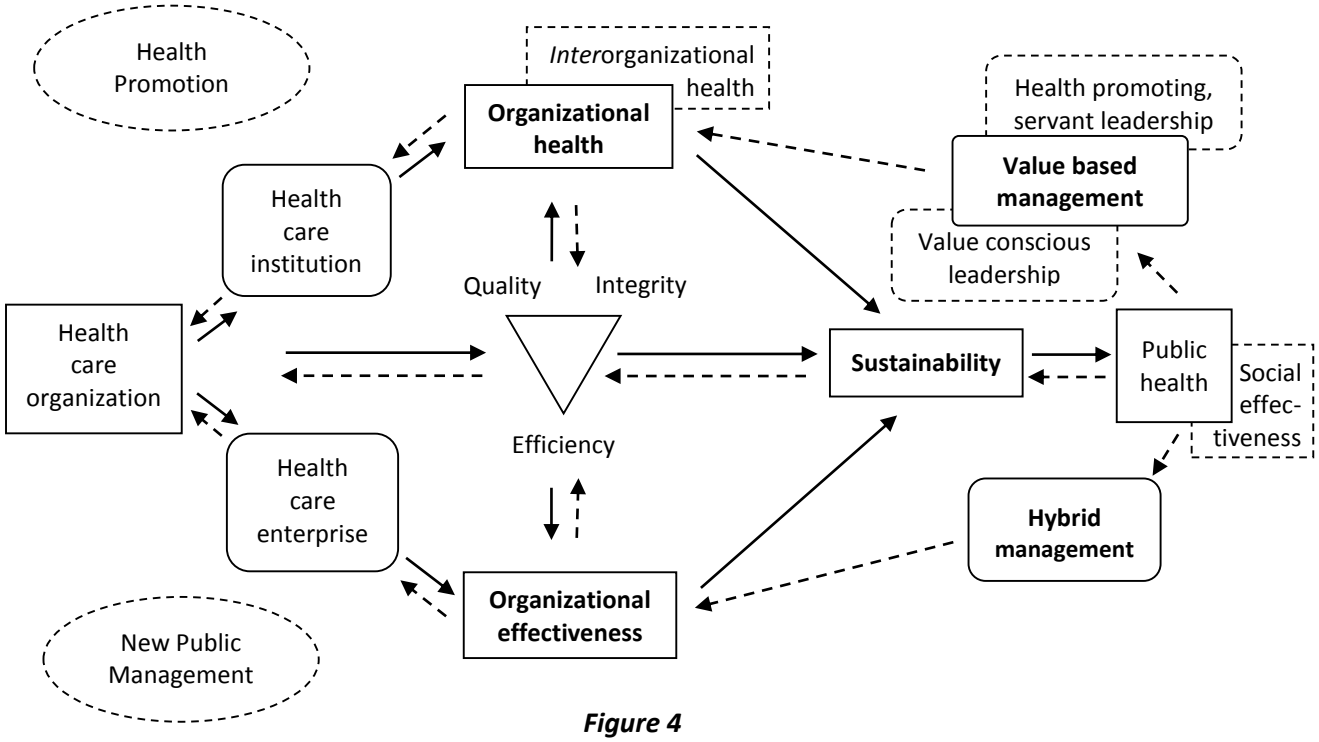

Figure 4

The revised model of organizational health

A model of organizational health, which is based on human values, rather than one which is focused on economic values should principally include issues related to the integrity and work health issues of all groups employed in organizations. This is important because improving organizational health requires a deepening and broadening of the understanding of work health, and the inclusion of all groups of employees is needed if this is to be achieved.

Paper II noted that integrity pressures experienced by managers at the first organizational level may pose considerable risks to work health and wellbeing, and that a hybrid strategy may be a sustainable approach to ensuring the health of ward managers and ensuring the health of an entire organisation. Integrity pressures are not restricted to professionals as first-line managers, but are also directly relevant to unskilled workers within organizational systems because they may also experience integrity-related work health problems. However, the focus in this thesis is on the integrity of health professionals and managers.

As suggested above, organizational efficiency and effectiveness formed the overall framework of understanding in the initial model presented in Paper I. In the field of public health and health promotion, both efficiency and effectiveness are potentially relevant dimensions (Tones & Tilford, 2001). However, efficiency and effectiveness are primarily associated with New Public Management – an ideology that may have underestimated the importance of other types of values within public organizations (Busch & Murdock, 2014). The sustainability of health care organizations and the significance of human values, such as the quality of patient care and the integrity of professionals and managers were viewed as central to organizational health. For this reason, organizational effectiveness was de-emphasized in the revised model. At the same time, the accentuation in the revised model of issues related to public health and sustainability was directly influenced by the findings of Paper IV, and indirectly by the findings

of Paper II, in which the sustainability of different management strategies was discussed. Together, these perspectives influenced the content of the revised conceptual model and my interpretation of its implications for public health management and leadership, and I turn now to explore these issues in more detail.

Bridging work health, organizational health and public health

As noted in Papers I, II and IV, a consideration of the work health of professionals and managers formed the starting point for the conceptualization of organizational health in this thesis. Traditionally, work health and workplace health promotion have been described on an individual and group level (DeJoy & Wilson, 2003). More recently, work health and workplace health promotion in health care organizations have been described more on an organizational level, but the research foundation for this still remains limited. In their research on organizational health interventions, Montgomery and colleagues (2013) note that one of the major challenges when promoting worksite health in medical settings such as hospitals has been to be context appropriate and, at the same time, theoretically sound.

According to Bauer and Hämmig (2014), the continuous interactions between individual and organizational capacities can be seen as a starting point of understanding organizational health. These interactions include an organization's everyday concerns and practices, which involve its members. This indicates that a conceptualization of organizational health in health care organizations should be underpinned by a consideration of the institutional traits of such organizations, that is, the characteristics of work, the issues of work health, and the sense making of health professionals and managers.

To understand work health problems on an organizational level, an organizational terminology is therefore needed, and organizational characteristics at different levels of analysis can help to explain work health. In a study of 90 workplaces in knowledge-intensive organizations, welfare services and other work organizations in Sweden, Marklund and colleagues (2008) found that a significant proportion of the variance in general health, work ability, musculoskeletal disorders, and sickness absence was attributed to workplace characteristics. Of eight tested characteristics, performance control and lean production could explain some of the workplace variance, while only one organizational effect was significant: high customer adaptation was associated with higher sickness absence.

The development and understanding of organizational health as a concept also requires a public health terminology and explanations that rely on multilevel analysis. While deepening an understanding of work health requires shifting how work health is understood from the individual and the group level, to the organizational level, similar shifts in focus from an organizational level to an interorganizational and societal level may be needed when attempting to understand organizational health in a public health perspective. Public health is the science as well as the art of promoting health through the organised efforts of society (Acheson, 1988). It also draws on wider interdisciplinary research about the health impacts of health care systems, environments and social structures (Ejlertsson & Andersson, 2009), and includes assessments of how policies, regulations and incentives can facilitate organized responses to health challenges (Laverack, 2014).

In the context of institutional theory, work health, organizational health, and public health correspond respectively to the levels of organizational units, organizations, and organizational fields. In this context, the latter refers to a unit, but also to a level of analysis. According to Scott (2008), an organizational field is a critical unit that bridges the organizational and societal levels, particularly

in studies of change, and connects organizational studies to wider social macrostructures. The interorganizational collaboration described in Paper III corresponds to the organizational field of hospital organizations and municipal health care organizations, and thus bridges organizational health and public health, as illustrated in Figure 5.

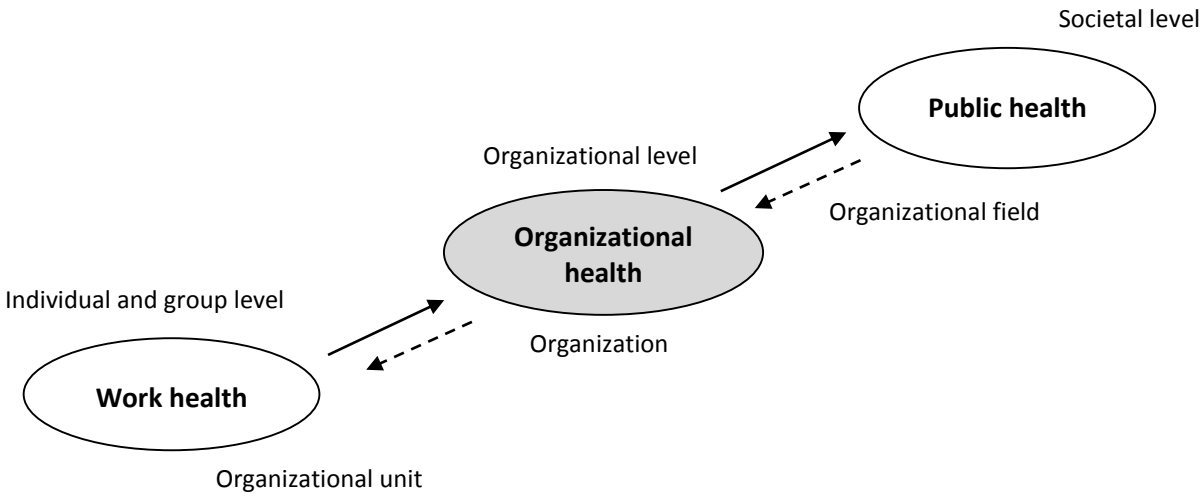

Figure 5

Bridging work health, organizational health, and public health

As suggested in Figure 5, the concept of organizational field can be included in a conceptual model of organizational health. According to Scott (2008), in an organizational field, participating actors are interacting more frequently and faithfully with one another than with actors outside the field, thereby forming a community and meaning system. However, this is not always the case in the organizational field of public health care. Data from Paper III indicated that collaboration worked well at the top level of the interacting organizations, but was more problematic on an operative level. In the latter, the concept of an organizational field was more likely to be linked to the notion of a space in which different agents with different social positions were located and struggling for power and resources.

However, the data in this study indicated that the collaboration on the operative level did improve and that it influenced positively on the quality of elderly care, as well as on economic efficiency, particularly for the municipality. In these particular circumstances, the understanding of organizational field as a social arena with common meaning and faithful interaction seemed more appropriate. Through the gradual development of a joint system of meaning between the collaborating actors, I argue that the collaborating organizations can – as actors of the organizational field – contribute to the health of the organizations involved. This even points towards dimensions of *inter*organizational health, which are discussed below.

The health of the organization and the health impacts of the organization

Inspired by Pelikan and colleagues (2014), and in keeping with the revised model of organizational health, two different discourses can be derived: the health *of* the health care organization and the *health impacts* on people *by* the organization. Organizational health,

understood to refer to the health of the organization, refers therefore to an organization as an autopoietic system which is able to survive in a sustainable way, depending on how it deals with competing institutional logics and value tensions, as noted in Paper I.

Using the first mode of discourse, organizational health could therefore be defined in terms of how well an organization is able to cope with the tensions of competing logics and diverse values to the benefit of the patients, the benefits of production, and the benefits to professionals and managers – and, by extension, to the organization as a whole. This discourse reflects the integration of values, for example of quality, efficiency and integrity, and the use of hybrid forms of management, as observed in Paper II, and of dominant, cycling and balancing management strategies, as identified in Paper IV. In these cases, organizational health also refers to the work health and wellbeing of professionals as clinical managers, and to their integration of competing values.

In other circumstances, the health of the organization may be promoted by positive disintegration. Managers who were characterized as quality-conscious in Paper II saw their primary responsibility as being that of ensuring high professional and ethical standards of treatment and care. They were conscious both of their professional backgrounds and their management roles, but placed emphasis on the clinical values at the expense of economic values. Disintegrative strategies were also used by the clinical managers taking part in the study reported in Paper IV, who worried about the future reputation of the hospital and placed an emphasis on the values of quality and integrity. Top managers, some of whom had been confronted by the threat of political decisions stopping the construction of the hospital exhibited disintegrative responses. They were therefore placing emphasis on cost control and measures of efficiency as a way of coping with pressures from internal and external stakeholders.

In such situations, dialectical perspectives can help to provide insight into the conflicts and diversity of values in organizations, as well as their mutual dependencies (Benson, 1977). To understand disintegration in this context requires a focus on the tension between organizational health and organizational effectiveness, as illustrated in Figure 4 in which human values like quality and integrity are emphasized in the inverse pyramid at the expense of economic efficiency. An understanding of organizational health as both integration and disintegration of competing values will be further discussed below.

The second discourse of organizational health relates even more directly to the health impacts on people brought about by health care organizations or the organizing and change of health care services. In the context of this thesis, the focus is primarily upon these impacts on health professionals and managers. However, the health impacts of organizational activities also potentially affect *all* employees, patients and families, as well as external collaborating partners. Like the first discourse, the second discourse is, principally, a comprehensive one, and also includes interorganizational elements.

In the empirical studies included in this thesis, several examples were identified of how an organization or the organizing influenced the health of patients, directly or indirectly. In Paper III, clinical managers in the hospital departments claimed that the personnel at the intermediate ward were not competent enough to take care of the jointly shared patients. This, they claimed, was a direct consequence of how the patient flows were organized, and had become a source of interprofessional and interorganizational conflict. In the same paper, it was noted that patients receiving transitional care at the intermediate ward were more satisfied than the

patients who were receiving all their treatment at the hospital: those in the former category were discharged to their homes more often, and appeared to have a higher level of functioning than the patients from the hospital. Such findings may have been associated with the mode of organizing their services.

In Paper IV, clinical managers referred to the way in which the multiple and radical change in hospital organization influenced the collaboration between physicians and nurses, and thus the quality of care, and the health and safety of patients. According to Pelikan and colleagues (2014), the health impacts on people caused *by* an organization should be an issue considered within the overall quality management system of the organization or within the corporate social responsibility scheme of an organization. In the revised model, health impacts therefore refer to the core elements such as quality, efficiency and integrity, but also include the issues of public health and sustainability.

The two discourses of organizational health noted above are different but also complementary. When referring to the health of an organization, the concept of organizational health relates to the notion of an organization as an organism, and to the cultural, structural and processual traits of the organization as a whole. The two discourses are rooted in different epistemological approaches, namely methodological collectivism versus methodological individualism (Gilje & Grimen, 1993). The epistemology of the first discourse is in keeping with that of methodological collectivism, in which a collective phenomenon like the health of an organization can be explained prior to the consideration of particular, individual facts. The second discourse, in contrast, focuses on the health impacts of organizations on human beings, and is characterized primarily by methodological individualism. All explanations of a social phenomenon are reduced to facts about individuals**.** In this second discourse form, organizational health is therefore an aggregation of the organizational impacts on individual health.

As individual work health can also be interpreted in the light of organizational culture, I would argue that both kinds of discourse are essential to conceptualizing organizational health. There are practical advantages to using both in the promotion of sustainable health care organizations and sustainable management. This is because management includes the management *of* health care services, as well as management *for* health. The two discourses are also complementary in relation to understanding conflict. Organizational health – when understood as the health of the organization – is necessarily characterized by a consideration of the oscillations occurring between integration and disintegration, and between harmony and conflict (cf. Paper I). An understanding of organizational health as the health impacts *on* human beings requires a more critical approach to interpreting the competing logics and value tensions in health care organizations – one that is more closely linked to postmodern hermeneutics. This critical approach may also serve as a reminder that the social mandate of health care organizations is to be both a human service organization and an institution, infused by human values.

Organizational health as integration and disintegration

Organizational health can be promoted through the integration of different logics and values, in line with a balancing strategy described by Fjellvær (2010). When managers pay attention to professionals who are worrying about the negative effects of performance-based payment systems on patient care, or when health professionals hear that managers are struggling with budgetary limits, a process of integration occurs on and across different organizational levels.

However, organizational health may also be promoted through disintegration, for instance, when competing values are encouraged and tensions are maintained in an organization.

In health care organizations, leaders' strategies may differ with regard to how they meet incompatible role demands due to competing logics and values. In a study of first- and second-line health care managers, Wikström and Dellve (2009) described how managers were able to tune in and tune out of the various logics they were coping with, depending on the tasks. In some instances, they used a concurrent process-oriented leadership strategy, based on dialogue, communication and cooperation. In others, they adopted a separating leadership strategy in which there was a fragmentation of tasks due to the competing logics and values. These two strategies correspond broadly to integration and disintegration processes, and may both be conducive to work health for managers and to the sustainability of health care organizations.

However, as noted in Paper I, efficiency is now seen as the main criterion for priority setting in many health care organizations. Although this development may have been necessary because of the pressures of coping with increasing health care expenditures, it has been a change associated with a concurrent transition from individualized patient care to a more standardized and efficient form of industrial service production. It has also been associated with an increase in the pressures upon health professionals and managers caused by such value squeezes (Crawford & Brown, 2011; Berg, 2012). In such conditions, disintegration could be seen as a way of sustaining competing values and as a form of collective sense making processes among these groups. In many organizations, however, competing values become fragmented rather than integrated or disintegrated. In a health care organization, this fragmentation can take place if, for example, important values systems become 'separated' from particular issues. Discussions about particular issues may be separated across management and clinical settings; some issues may be discussed in purely economic terms while others may be talked about in terms of their professional implications (Orvik & Vågen, 2010).

As noted in Paper IV, this fragmentation of values was illustrated by the actions of some of the clinical managers. By responding differently to different situations in which they were experiencing value squeezes, they adopted a so-called cycling strategy (cf. Fjellvær, 2010):
In meetings with top managers, they were apparently able to accept cuts in staffing, but in staff meetings, they expressed support for their colleagues who were frustrated by these same cuts. The value tensions, in these instances, were separated and isolated. Over time, such discrepancies may impair the legitimacy of managers among their clinical colleagues and present risks for their own integrity and work health. However, as Pettersen and Solstad (2014) have noted, clinical managers may also have institutional rights to exercise their professional and ethical judgements. These may not necessarily be stipulated in the formal contracts they have with the top managers and they may have budgetary consequences that are not accounted for in transformational plans. Pettersen and Solstad also found that different contexts and the professional backgrounds of clinical managers also lead to different patterns of responses with regard to how the managers dealt with the triangle of competing professional, enterprise and communicative logics.

In health care organizations, contradictory logics and value tensions can be swept out of sight, but doing so is not healthy for an organization as a whole. As noted in Paper I, such strategies may even lead to a form of 'organizational schizophrenia' in the long-term (Melander, 1999).

The interorganizational dimensions of organizational health

The processes of integration and disintegration, as described above, are explicitly linked to the competing values and value tensions affecting organizational health, including those associated with the provision of patient care. The mandate of health professionals and health care organizations is to promote health and provide care of high quality. However, as organizations are highly differentiated and contain highly specialized professions, such care may become fragmented. Different forms of integration and collaboration are therefore required, including cumulative types of interprofessional, interorganizational and intersectoral collaboration (Axelsson & Bihari Axelsson, 2006, 2013). While integration and collaboration are important to patient care in general, the findings from Paper III illustrate that they are particularly important in the context of transferring patients. Interorganizational integration refers to joint efforts by professionals and organizations involved in the coordination of health care services (Willumsen *et al.*, 2012). This integration often has positive connotations for those involved, but has proved to be hard to achieve in practice (cf. Wihlman, 2009), particularly when trying to provide seamless health and social care services in complex systems, and in times of radical organizational change.

Integration in health care services can be understood as being on a continuum ranging from full integration to full segregation in which there is no integration or contact between professionals or organizational units (Ahgren & Axelsson, 2005). In the study referred to in Paper III, positive contacts did happen and there was an apparent state of integration between some managers and units. In the project group and in the steering group, representatives from both organizations encouraged integration through joint efforts to establish a good climate of collaboration. However, the interface between the hospital departments and the intermediate ward was characterized by antagonistic contacts and conflict, and could be described more as a state of disintegration than a state of segregation, which means an absence of contact. In the study reported in Paper III, the ward personnel indicated that they felt cheated by their colleagues in the hospital departments, and even suggested that their colleagues wanted to punish them by not sending them any patients at all. Destructive climates of this kind may compromise collaboration. However, it could be argued that such a state of disintegration could also be a necessary way of dealing with conflicts on different levels within an organization and between organizations, and could gradually contribute to integration and collaboration.

Thus far, organizational health has been examined mostly in terms of intraorganizational processes and perspectives. However, organizational health should also be understood in terms of the influence of interorganizational collaboration and environments, as shown in the revised model of organizational health shown in Figure 4. The growing recognition of a potential connection between interorganizational collaboration and organizational health echoes the emerging recognition of the importance of *inter*organizational health. The proposed interrelationship between these elements is illustrated in Figure 6. This potential connection between interorganizational collaboration and interorganizational health can primarily be understood within an abductive, free and scientific framing, rather than analysed via empirical data. A tentative concept of *inter*organizational health can also be related to different forms of health management and leadership, in the same way as organizational health.

In the connection of interorganizational health, the concept of altruistic leadership seems particularly interesting. A key focus in altruistic leadership is that the roles of health professionals and managers can be transformed and that they are willing to see their activities in terms of the needs of patients and the wider society (Bihari Axelsson & Axelsson, 2009). As

illustrated in the description of the study reported in Paper III, it usually takes a lot of time and energy to establish and maintain interorganizational collaboration. This is probably also the case with an altruistic orientation.

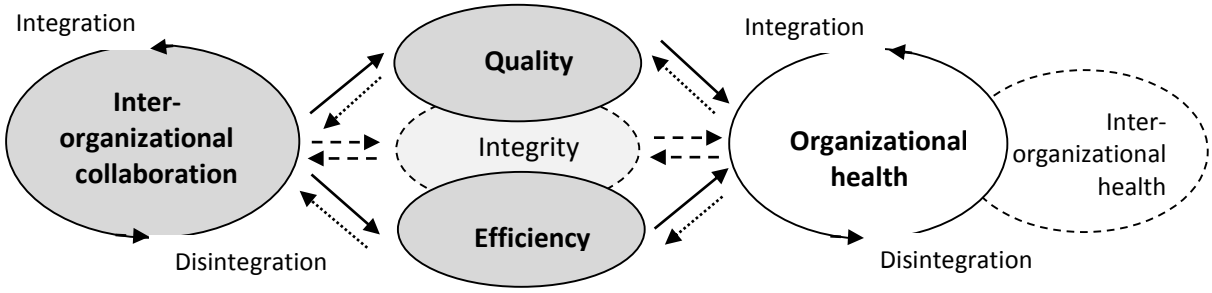

Figure 6.

Potential connections between interorganizational collaboration and interorganizational health

Figure 6 maps the suggested connections between interorganizational collaboration and organizational health in two ways. The first connection is between interorganizational collaboration and organizational health, and can be described as a series of oscillations between integration and disintegration. This iterative process can be seen as necessary in the context of interorganizational collaboration as well as in the context of organizational health. Interorganizational collaboration and organizational health are also connected in a second way through the values of quality, efficiency and integrity, as noted in Figure 6.

Integration and disintegration in interorganizational collaboration can influence quality and efficiency, as is shown in Paper III. Integration and disintegration in the context of interorganizational collaboration are also connected to the concept of integrity; in the context of employment and work health, integrity is related and integrated in both intra- and interorganizational environments (Schabracq, 2003). Integrity requires a continuity between values and the actions performed, which should therefore not be in conflict with individual convictions. This was not always found to be the case in the study described in Paper III. Instead, as noted above, clinical personnel at the hospital regarded their colleagues at the intermediate ward as being unqualified to take care of the transferred patients. They also felt that the collaboration project had been forced upon them and that, as such, it was a waste of time and other resources. Such reactions could be interpreted as a form of resistance to change. However, the apparent sense of incongruity in the clinical setting and the disintegration of the participants' sense of belonging during the collaboration project could also be seen as reflecting an unwillingness to perform work that was not in accordance with their personal values. As such, their resistance could be interpreted as their own way of sustaining their integrity. In processes of change, the sustaining of value tensions and disintegration through resistance could even be seen as a condition for maintaining the integrity of clinicians and managers.

While Paper I described the oscillation between integration and disintegration as related to values and to organizational health, Paper III illustrated a corresponding, iterative process related to interorganizational collaboration. In this study, a hospital nurse suggested that it might be worse for patients to stay at the hospital and even more expensive for the hospital,

compared to patients receiving care at the intermediate ward. This balancing of value concerns related to quality and efficiency illustrates the effort required to reach a state of integration and collaboration. In other contexts, conflicting quality and efficiency demands may have challenged the integrity of professionals and of clinical managers, and thus their collaborative relations. The conflicts associated with the lack of trust described in Paper III were illustrative of short-term barriers to collaboration and integration, and were examples of a state of disintegration in the short-term.

However, such a disintegration could facilitate negotiations of conflicts in the long-term and contribute to longer-term collaboration and integration. As such, they can be interpreted as potentially useful and necessary to the promotion of interorganizational health.

The horizontal and vertical dimensions of the conceptual model

The elements of organizational health discussed above are examples of the horizontal and vertical dimensions illustrated in the revised model in Figure 4. The horizontal dimensions in the diagram refer to public health and sustainability as goals and to the contributions of health care organizations to ensuring societal effectiveness. The vertical dimensions refer to contradictory, institutional logics, competing values, and associated value pyramids, but also to tensions between different forms of management and leadership. Evaluating the validity of the conceptual model proposed could begin with a consideration of these horizontal and the vertical dimensions. This would require clarifying the interrelationships and tensions between the different elements.

In evaluating and validating the conceptual model of organizational health, attention could also be given to the relationship, among the vertical dimensions shown, between the goals of sustainability, public health, societal effectiveness and the idea of organizational health on the one hand, and the goals of sustainability, public health, societal effectiveness and the idea of organizational effectiveness on the other. The apparent tensions between human values and economic values, and the parallel tensions between the values associated with health institutions and health enterprises could be another useful line of enquiry. Further evaluation and validation of the conceptual model should also include an examination of the tensions between different forms of management and leadership, which are discussed in more detail below. I turn now to answering the second key research question in this thesis.

Implications for public health management and leadership

In Paper II, different management strategies for coping with integrity pressures were identified and their possible implications explored. A hybrid management strategy appeared to be the most sustainable with respect to work health and the wellbeing of managers and, most likely, for their respective organizational units as a whole. In Paper IV, the analysis of value tensions revealed the use of an implicit hybrid management strategy guided by three integrative management strategies. Among these strategies, the *balancing* of competing values and demands seemed to be the most integrative and sustainable.

Hybridization may be a useful strategy for professionals as clinicians as well as for managers, and for professions as well as organizations (Kurunmäki, 2004). Hybridization has even been characterized as a condition for the survival of professions (Fältholm & Nilsson, 2011).

However, in the theoretical framework, hybridization is described as multifaceted, and alternatives should therefore be considered. Value based management and strategies associated with the value based form should be among those considered.

From hybrid management to value based management

According to Jacobs (2005), hybridization implies that there has been a fundamental change to a profession, analogous to a genetic change of a species. Jacobs argues that the term polarization should be used in conjunction with hybridization, to differentiate between situations in which responsibilities for finances and accounting involve only a limited group of people in the medical profession, compared to a hybridization involving a whole profession, for instance the physicians.

Hybridization in the health care sector has also been described as a form of navigation between clinical and leadership roles, which nourish a sense of double identity (Sørensen *et al.*, 2011). Llewellyn (2001) has even referred to hybridization as a 'two-way-window'. This latter analogy highlights the way hybrid managers, in effect, look between, and act in, two different worlds – i.e. the professional and the managerial – instead of operating mostly or only within one world. This means that hybrid managers have to combine different institutional logics and professional expertise in their management roles (Berg *et al.*, 2010). When professionals as managers are obliged to act within, and be translators between, completely different worlds, cognitive dissonance may arise and carry emotional costs and tensions. The use of hybrid teams instead of individual hybrid roles may therefore be a more functional alternative strategy (Choi, 2011). As noted in Paper I, the concept of disintegration needs to be included as a constituent element in a new conceptual model of organizational health, particularly as hybridization is associated with such states.

As shown in Figure 4, hybrid management can be understood as a characteristic of New Public Management and health enterprises, which focus on values associated with productivity, efficiency and organizational effectiveness. A hybrid management role could also be interpreted as a role that should therefore contribute to the achievement of these goals. However, according to Kippist and Fitzgerald (2009), divergent clinical and managerial objectives can also cause conflicts that may have negative implications for efficiency; clinical managers in hybrid roles may therefore not bring with them the organizational effectiveness expected in such roles. In other circumstances, hybrid management may be a sustainable strategy for the managers themselves as well as for the professionals, the organizational unit, or the organization as a whole, as is suggested in Papers II and IV.

It has been argued that health care management and economic constraints can coexist in contexts involving the promotion of quality in patient care (Cara *et al.*, 2011). However, hybrid management is not necessarily trouble-free. As the revised model of organizational health indicates in Figure 4, human values such as quality and integrity are connected to the notions of the health institution and to health promotion. Given the tensions inherent in the use of a hybrid management strategy, a value based management approach with a focus on human values may be an alternative and sustainable strategy. Another strategy has been the incorporation of a value based form of management into hybrid management (Graber & Kilpatrick 2008). While hybrid management was introduced in the wake of New Public Management, it has been suggested that a combination of hybrid and value based management

could show the way forward into a new, post-New Public Management era (McNulty and Ferlie, 2004; Christensen, 2012).

As suggested earlier in this thesis, hybrid roles in the context of New Public Management are expected, ultimately, to transform into general management roles (Berg *et al.*, 2010) with enhanced responsibilities for developing cost-effective managerial skills in clinical management (Causer & Exworthy 1999). In Paper II, a hybrid management strategy was shown to be potentially better than quality conscious and efficiency-adjusting management strategies, both for the clinical managers themselves and the hospital wards and organizations as a whole – despite the fragmentation risks associated with a hybrid strategy. However, hybrid management which is inspired by New Public Management can also be characterized as a form contributing to adjustment and harmony, rather than the dialectical perspective presented in the conceptual model of organizational health introduced here. Most likely, other forms of management and leadership can do more to sustain these values tensions and enable positive disintegration.

Value based management and value conscious leadership

Health professionals as leaders must balance professional and managerial values, and be Janus-like in facing towards very different worlds. Each world has its own and often collectively contradictory logics, and the bridge linking these worlds often lacks a solid foundation (Witman *et al.*, 2011). It could be argued that value based management offers the necessary solid platform for health professionals as leaders in their encounters with the management world. However, value based management strategies are often more implicit than explicit in nature.

In Paper II, the ward managers were found to be working in accordance with ethical values and standards of care. Though some managers were more rigorous than their colleagues in terms of the professional standards required, none labelled their own management practice as value based. In the interorganizational collaboration described in Paper III, some managers and clinicians at the hospital departments articulated a lack of trust in the clinical personnel at the intermediate ward, whom they regarded as being insufficiently competent to take care of the shared patients. These critical statements may have reflected an indirect value based managerial practice or a professional practice. In Paper IV, clinical managers were found to be passionately engaged in quality issues. At the same time, they were sceptical about the new hospital building and whether it would be possible to ensure and improve the quality of patient care. The top-level managers emphasized that patient care and clinical work were the core missions of the new hospital organization. Both the clinical managers as well as the top-level administrative managers acknowledged the limits of achieving efficiency, but also the significance of doing so. In such instances, value based management was being practiced implicitly, but it was not characterized as such. In these instances, value based management appeared to embrace either the balancing of two different worlds of human values and economic values, or efforts to focus on just one of them.

The core idea of value based management is the *use* of values as a source of motivation and energy, and as a way to make sense of and promote commitment to an organization (Aadland, 2004). Which, or whose, values should be used, sustained and even protected? The values associated with professional practice and management in the public sector, it can be argued, would appear to be stable. These include values such as those reported in a Danish study of public administration: accountability to society, due process, equal opportunities, and

transparency (Jørgensen, 2007). Similarly, in a survey of health care managers in a large Norwegian municipality, Busch and Wennes (2012) found that the concerns at the heart of public service were professional standards, the meeting of the needs of individual users, due process, and loyalty to political decisions, renewal and innovation, and continuity.

In hospitals, clinicians often implement new technologies but it is top-level managers who 'implement' the new organization (Glouberman and Mintzberg, 2001). Neither group, however, is a guarantor of human values. The transformations associated with organizational or technological change may even be detrimental to hospitals as human institutions (Slagstad, 2012). Reorganization and institutional change in the organizational field may also change values in the public sector, and new values and value tensions may need to be addressed. Paper IV reports on high-tech solutions and a new matrix organizational model implemented in the form of a nursing division in a university hospital some months ahead of the relocation. These changes influenced the collaboration between physicians and nurses: they directly affected the quality of the patient care, and – indirectly – influenced efficiency and even integrity. Values can vanish (Bentzen *et al.*, 2013), and values in professional practice and management and can be altered in change processes, particularly when they are as radical and multichanging as those referred to in Paper IV.

There is a significant difference between being anchored in established values and being associated with the development of values in the present and in the future (Busch, 2011). In keeping with this perspective, the revised model illustrated in Figure 4 indicates that there is a need to differentiate between the forms of value based management and value conscious leadership. When the organization and the environment are known and stable, health managers and clinicians can continually anchor their practice in established values. However, when values, organizations and organizational fields are being changed or are unknown and unstable, managers and clinicians must develop new values by learning, reflecting and leading – a process illustrated in Figure 7.

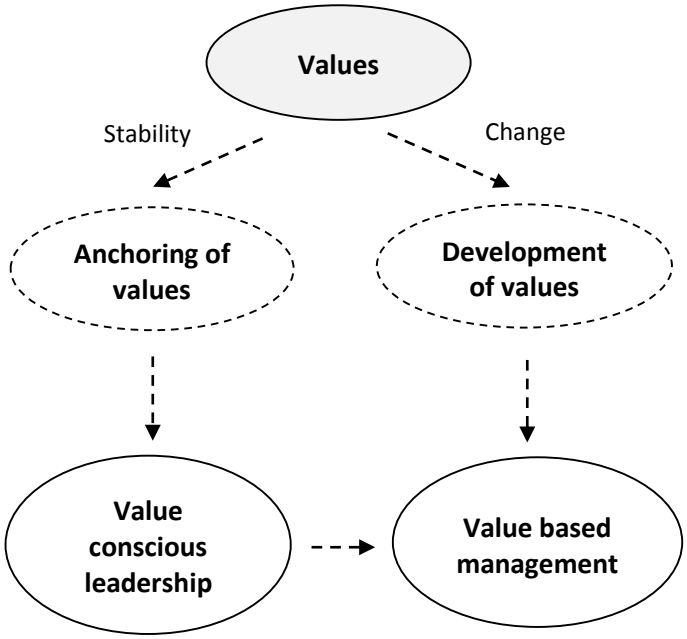

Figure 7

From value based management to value conscious leadership

Managers and clinicians should be conscious of the changing horizon of events and be able to lead. In situations of instability, the concept of leadership may be preferable to the concept of management. Management refers to formal systems and concrete issues such as goal setting and planning. Leadership, in contrast, refers to human and transformational relationships between leaders and colleagues within systems of change (Orvik, 2015). It is characterized by unknown, informal systems, and the organisation of people while introducing new and changing systems and cultural values (Eriksson, 2011).

Leadership is associated particularly with managing and handling unexpected situations, and has been described as a social process of influencing work (Sveninsson *et al.*, 2012). The essence of leadership is also catalytic, particularly in ambiguous situations in which different institutional logics are present (Berg, 2015). The field of public health care is characterized by situations of stability as well as situations of instability. Therefore, the differentiation between value based management and value conscious leadership is significant in this context.

Value based management and health promoting, servant leadership

Neither health promoting leadership nor servant leadership was introduced or discussed in the five articles in this thesis. Health promoting and servant leadership, like value conscious leadership, can be regarded as an extension of value based management. Together, value based management and these two 'extensions' of value-based management constitute a cluster of forms and have been included in the revised model of organizational health shown in Figure 4.

The connections between health promoting leadership and servant leadership in the field of public health are multiple. Health promoting leadership is particularly concerned with individual and organizational capacity building for sustainable workplaces in which employees are participating. It is also associated with servant leadership, the aim of which is to develop and empower employees professionally and personally through serving them (van Dierendonck, 2011). In addition, the connections between organizational health and health promoting, servant leadership are multiple. Organizational health ought to be based on an inverse value pyramid in which the needs of patients and health professionals should be of fundamental importance (cf. Paper I).

With its focus on work health and the empowerment of employees, health promoting, servant leadership is compatible with this approach, in which staff and patient outcomes are the ultimate focus. Health promoting, servant leadership is therefore coincident with the core idea of organizational health being of benefit to patients, professionals and organizations as a whole. However, health promoting, servant leadership can also promote organizational health. As such, this means that health promoting, servant leadership is an implication of organizational health and a means to promote it. This also implies to serve employees.

Are there other and better ways of building sustainable workplaces and developing and empowering employees than being served by leaders? Organizational researchers have associated servant leadership with the empowerment and development of people (e.g. van Dierendonck, 2011), and to job satisfaction and better performance (Gunnarsdóttir, 2014). Others have characterized health promoting leadership as a strategy to build individual and organizational capacity for sustainable workplaces (Eriksson *et al.*, 2010). Its relevance to health promotion can be recognized in the findings reported in Paper IV: some of the top

managers warned against making shortcuts when managing clinicians, and pointed out that the clinicians should be treated with respect.

Inspired by the philosophy of Lévinas (2006), respect for *the other* had been a value premise in the early stages of the hospital planning reported in Paper IV. However, there had been considerable resistance to this idea among clinicians and clinical managers. Their main objection had been that the frenetic activities associated with the hospital clinics did not constitute a good framework in which to implement such a comprehensive approach. So does this also mean that ideas of health promoting, servant leadership and the ideas of empowering employees cannot be implemented in busy health care organizations? This may not necessarily be so, but it also illustrates the potential challenges and barriers involved in implementing the philosophy of organizational health, with human values embedded, in health care organizations.

In conclusion, four forms of management and leadership have been highlighted in terms of implications of organizational health. I have shown that hybrid management is multifaceted and has been inspired by the ideology of New Public Management. As such, it should be supplemented with management strategies associated with more value based and value conscious forms. A shift from hybrid management towards more value based and value conscious forms is justified by the need to promote human values in health care and other human service organizations. With its explicit focus on the empowerment of employees and on their work health in line with core ideas of organizational health, health promoting, servant leadership may have significant potential impacts on health care organizations.

Chapter 8:

Methodological discussion

Progressing from a preliminary to a revised conceptual model of organizational health involves diverse methodological approaches, and these have been described in the relevant papers. A postmodern hermeneutical approach with its critical appraisal of values within modern organizations and societies is referred to explicitly in Papers IV and implicitly in Paper I and Paper II. In these studies, some of the characteristics of New Public Management were critically assessed. This ideology, which has been shown to underestimate the importance of professional and public values, is characterized by a biased orientation towards economic values. However, it has taken a firm hold in hospitals and other health care organizations. New Public Management has been criticized for its tendency to describe work health problems on an individual and group level rather than an organizational and interorganizational level. The new conceptual model of organizational health introduced here is implicitly critical of New Public Management, which has been characterized as a form of individualized accountability.

Another methodological approach used in the conceptualization process was applying a combination of content analysis and template analysis, as detailed in Papers II, IV and V. In Paper I, the value clusters were related to the patients, the production of care, and the professionals. These value clusters formed the key elements of the preliminary model, as well as the nodal values of quality and efficiency. In the subsequent papers, the template was expanded to include the nodal value of integrity, and in the revised model of organizational health, quality, efficiency, and integrity emerged as nodal values. These were found to be dominant and had a large number of related neighbour values. As such, they were of greater importance than the other values (Jørgensen, 2006). The importance of the three nodal values was demonstrated by showing how each occupied a central position within a network of values, as illustrated in the template analysis. These values directed the conceptualization process further, and may have helped to make the model of organizational health more manageable. In the questionnaire studies of Paper III, the specific focus on quality in connection with the transfer of elderly patients and on interorganizational collaboration led to the integration of interorganizational dimensions into the model of organizational health.

However, it could be argued that the inclusion of the three nodal values mentioned above may also have narrowed the conceptualization process. For example, the specific focus on integrity in Paper II may have contributed to a deeper understanding of the connection between integrity, work health and organizational health, but it may also have limited the researchers' angle of investigation and the knowledge construction related to professionals as ward managers, their work, their work health, and their wellbeing. As noted in Paper V, the use of supplementary, integrative themes can facilitate a more holistic analysis than might otherwise be possible if a template approach is used (King *et al.*, 2002). This means that nodal values can be modified and templates changed. By doing so, the conceptual model of organizational health in health care organizations can be extended beyond and across the nodal values of quality, efficiency and integrity. While these nodal values may have narrowed the scope of conceptualization, they may also have contributed to expanding the potential applications of the conceptual model and helped to increase its validity for different types of human service organizations.

Paper V appears initially to be less directly connected to the thesis than the other papers. As suggested above, the starting point of this methodological and epistemological study was a

discussion among researchers involved in the trailing project described in Paper IV. One of the key issues considered was the significance of the contextual factors in the analysis of qualitative findings, especially in the focus group discussions used in the trailing project. According to Denzin and Lincoln (1998), qualitative data are influenced by how people make sense of experiences within research contexts. From a constructivist and hermeneutical point of view, data cannot be separated from the context in which they are found; instead, data are created in, and through, the processes involved in the making of meaning (Kvale & Brinkmann, 2009). One of the conclusions of Paper V was that a consideration of contextualization in the form of the situational factors contributed to increasing the validity of the description and analysis of the data. By extension, one may similarly suggest that contextualizing work health in the contexts of organizational health and public health may also contribute to a more valid description and analysis of work health issues in health care organizations.

Paper V is also connected to this thesis particularly with respect to the use of the template analysis model. In addition, the core concept of situational factors, which inspired this methodological paper, is a sensitizing concept (Blumer, 1970), as is the concept of organizational health. This means that the substance of the concept was developed and deepened through a continual process of interpretation and modification, and through a combination of deductive, inductive and abductive reasoning. This methodological approach was mentioned explicitly with regard to the preliminary model presented in Paper I, and was embedded in the continuous process of conceptualization that lead towards the development of the revised model.

Situational factors and organizational health are both abstract concepts and can be characterized as either experience-near or experience-distant (cf. Geertz, 2000). Researchers can use them to reflect theoretical and practical aims. In this thesis, the inclusion of experience-distant concerns in the process of conceptualization was needed to enable professionals and managers, over time, to reflect on and respond to work challenges on an abstract level. When gradually used by participants such as health professionals and managers, the concept of organizational health itself may also change from being experience-distant to being more like an experience-near and everyday concept.

The three empirical papers included comments by professionals and managers in settings of managing quality deviations, interorganizational collaboration, and radical organizational change. Participants only occasionally expressed awareness of concepts which could be related to organizational health in these settings. However, by broadening the understanding and horizon of work health, their experience-near descriptions were crucial in deepening the substance of organizational health. It is evident therefore that experience-distant and experience-near approaches were both needed, and intertwined, in the interpretation and modification of this conceptual model.

The epistemological oscillation between experience-distant and experience-near concepts was reflected, too, in the tensions between nomothetic approaches, which relate to theoretically generalized knowledge and ideographic approaches, and aims, which generally relate to knowledge that is more specific and contextual. This tension was relevant to the understanding of situational factors as well as to the development of a conceptual model of organizational health. With its substantial focus on issues of work health, stress and coping among health professionals, the ideographic approaches used in Paper V were an important contribution to the process of conceptualizing organizational health in the field of health care organizations. At the same time, the nomothetic approach and the general methodological elements connected

with the conceptualization of the situational factors in Paper V also helped to inform the conceptualization of a model of organizational health and have potential relevance to other human service organizations. The introduction, in Paper II, of quality, efficiency and integrity as core elements also contributed to the revised conceptual model.

In this thesis, qualitative studies constituted the methodological 'drivers', but were supplemented by mixed methods. In the qualitative analysis in Papers II, III and IV, an ideographic approach was used, including substantial descriptions of organizational health issues in specific health care contexts. The exploration of the need for a new conceptualization of organizational health was examined within the Nordic context, and the empirical studies were conducted in Norwegian health care settings. The conclusions are therefore relevant and valid for organizational health issues in health care organizations in Norway and other Nordic countries. However, the conceptualization was also informed by reviews of research from other countries, as was the analysis of the empirical findings. The conclusions may therefore be transferable, with some modifications, to other settings.

In addition, the tensions between quality, efficiency and integrity, and the challenges in the wake of New Public Management and its dominance in the public sector, may be transferable to other human service and welfare organizations. This nomothetic approach to organizational health is consistent with the logic of the public health platform included in the revised model of organizational health, in which the principles of health for all and in all policies and settings, supplemented by a reorientation of health care, forms a central premise. The conceptualization of organizational health presented here, I would argue, is therefore potentially relevant across different sectors of society.

The methodological approaches used in this thesis were mainly qualitative, and brought with them associated strengths and weaknesses. In critical appraisals of qualitative research, trustworthiness is understood to refer to the credibility, transferability, dependability and confirmability of a study (Lincoln & Guba, 1985), while the criterion of authenticity is understood as referring to the extent to which the realities of a study are investigated fairly and faithfully (Guba & Lincoln, 1989). To achieve authenticity, researchers should present all the views and conflicts in the investigated cases, and indicate whether the findings appear to be authentic to the participants.

To ensure the *credibility* of the study, data were collected from different settings, though mainly from hospital organizations. The data were also collected from different organizational levels, using different methods and a range of sources, and were characterized by variation, but also by thick descriptions.

Issues related to the *transferability* of this research have been mentioned above, and relate to whether findings can be applied beyond the specific contexts of the study (Malterud, 2001). Considerations of transferability also relate to how far, and how much, research findings can influence discourses within other organizational fields. The theoretical frame of reference and the inclusion of international research has potentially strengthened the potential for the transferability of the findings from health care settings to other human service organizations, and even from the Nordic region to other regions. However, the use of a wide theoretical frame of reference may also have been influenced upon the depth of the study and the scope of the research.

Dependability refers to the stability and consistency of data. In collecting empirical data and including articles, efforts were made to ensure that future researchers could repeat the study. In Papers IV and V, decision trails carefully documented and illuminated the steps taken by the reseachers during phases of analysis and interpretation.

To achieve *confirmability*, steps were taken to make sure that the findings, which emerged, came from the data rather than from preunderstandings and prejudices. Discussions with other researchers during the analysis process was one way in which I attended systematically to the context of knowledge construction. It included reflections on how the researcher was also a subject in the research process, and is discussed in detail in the section examining the issue of reflexivity, above.

To ensure the *authenticity*, each participant in the empirical studies referred to in Papers IV received transcripts of their own interviews to assess their responses and to confirm whether they approved. In this way, the interview results were validated in accordance with qualitative methodology. This co-construction of data may have helped to a closer synchronization of the participants' version of their reality and the researchers' construction of the data. This may have contributed to a more accurate interpretation of the investigated phenomena. In many of the studies which are referred to above, multiple and mixed methods were used to achieving greater authenticity.

Chapter 9:
Conclusion

The aim of this thesis was to contribute to an understanding of organizational health by introducing a new conceptual model of organizational health and clarifying its key elements, particularly with respect to public health organization, management and leadership. In order to create this type of new knowledge, multiple theoretical and empirical data sources were utilized, which also drew on the researcher's own practical experiences. This new knowledge has been created through interdisciplinary interaction, a process in which different disciplines mutually influence each other through their interactions in a common, overlapping field and across disciplinary and professional boundaries (Leathard, 1994).

In the context of this thesis, the interdisciplinary interactions bridged the fields of public health organization, management and leadership within a framework of institutional and settings perspectives. The thesis also bridged the fields of work health, organizational health and public health, and developed a new conceptual model using analytical induction to integrate empirical data. By anchoring the previously used concept of organizational health in theories and empirical research, it has also substantially advanced the understanding of the phenomenon and the definition of the concept.

The conceptual model shows the importance of a renewed consideration of human values in health care organizations – an issue of urgency when seen against the backdrop of New Public Management. There is a need for a new form of management in future health care services, with respect to the health of patients and the work health of professionals. Economic values are typically included in models of organizational health, but their impacts need to be critically appraised. Changing from a focus on organizational efficiency and effectiveness to a focus on organizational health and sustainability may be a radical one, but it is a necessary step in advancing a paradigm shift from management ideas developed in non-interactive fields such as industrial production, to interactive fields such as patient care.

The new conceptual model of organizational health presented here can help to challenge the ideas and methods of New Public Management in health care and other human service organizations. The development of a new model presented here can also help to broaden the horizon of the understanding of work health, and an understanding of how health issues in health care organizations can be linked to issues of public health. The conceptualization has been informed by different focus areas: the health of an organization as a whole, and the health impacts of organizations on people. Organizational health, it has been noted, can also be seen as an oscillation between integration and disintegration of values, and dimensions of interorganizational integration and collaboration indicate the significance of integrating interorganizational concerns into future, more comprehensive models of organizational health. These conclusions are central to answering the first research question. Hybrid management and value based management extended by value conscious and health promoting, servant leadership, highlight the second question.

The findings have also highlighted the importance of considering the horizontal and vertical dimensions of organizational health. While the horizontal dimensions presented in the model referred to sustainability and public health as goals and to the contributions of health care organizations to ensuring societal effectiveness, the vertical dimensions refer to the

contradictory, institutional logics, competing values, and associated value pyramids. The vertical dimensions also included those between hybrid management on the one side and strategies of value based management, value conscious leadership and health, promoting leadership on the other. Both the horizontal and the vertical dimension should be considered in future research, and the process could begin with an evaluation and validation of the conceptual model proposed here, a consideration of the interrelationships between the different elements of the model, and the effect of organizational health on sustainability and public health.

Operationalizing the conceptual model might be a useful next step in future assessments, as well as the development of measures for the evaluation of the intermediate and long-term effects of organizational health. An operationalization of the conceptual model could begin with the development of measures for the evaluation of integrity, which so far have been less operationalized than measures relating to quality and efficiency. The extended use of mixed methods and statistical analysis is recommended, and should culminate in an operational definition of organizational health. The model introduced in this thesis is based on a holistic analysis and has drawn on the connections between theories, empirical studies, and practical experiences. Its aim was to make these processes and tools clearly visible and heuristic. Doing so, it can be hoped, will enable this model to be relevant to future health care services and management, and to the promotion of elements of applied research and development.

In the wake of the trailing research described in Paper IV, pilot projects on management for health promoting workplaces have been initiated in two clinical departments at the university hospital referred above, which has been accredited as a health promoting hospital by the World Health Organization (Orvik *et al.*, 2016). The hospital's plan for strategic development indicates that making the hospital a health promoting workplace is essential. The aim of the pilot projects was to develop methods for implementing the principles of workplace health promotion. Thus far, such efforts have tended to focus on health resources among clinicians and clinical managers, and consistently looked for ways to nurture their capacities to cope and live with their work health challenges and stress. Psychological strategies such as coping, resilience and mindfulness, I would argue, are in line with management forms characterized by individualized accountability, and the concepts associated with New Public Management.

The revised model of organizational health suggests that the projects mentioned above could benefit by extending their focus from individual work health and capacity building to a wider focus on organizational health and capacity building – one in which different elements of the model could be integrated, and different levels of management could be involved. Shifting the focus from pilot projects to research projects will require analysis of multiple levels within hospital settings. In general, applied research and development tend to solve practical and context-specific problems, and necessarily require pragmatic methodological approaches. As in other forms of research, it will be crucial to ensure the transparency of the methodological approaches used in research on – and the implementation of – a conceptual model for organizational health.

Finally, future research should introduce and explore new questions related to the reconceptualization of organizational health. While the focus of this thesis has been on the conceptual model and its implications for public health organization, management and leadership, it may also be valuable to explore how different forms of public health management and leadership can promote organizational health. This alternative approach may have theoretical as well as practical value. A number of theoretical perspectives have been outlined above, and it has been noted that while value based, value conscious, and health promoting and servant forms of management and leadership point towards the importance of organizational

health and human values, the hybrid management form is associated more towards New Public Management and its appurtenant economic values. As suggested in the framework of this thesis, similar forms, such as altruistic, transformative, appreciative, communicative, and caritative leadership may also influence organizational health through their stronger orientation towards human values. These, too, could be explored in future research and inform revised conceptualizations.

It is hoped that this future research will have practical benefits through the implementation of forms of management and leadership that can also promote organizational health in health care organizations. In many instances, health care organizations have been heavily impacted by the ideas of New Public Management and its emphasis on values of productivity, efficiency and effectiveness. Value based management and associated forms of leadership suggest that alternative post-New Public Management approaches are possible. This new ideology may even come to be referred to as New Public *Health* Management and Leadership. In this context, it can be necessary to reinforce the need for a future reorientation of health care organizations – one that is more health promoting and more focused on people. This could be of benefit to patients, to professionals and to managers, and thus to health care organizations as social actors.

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SUMMARY

The thesis introduces a new conceptual model of organizational health and discusses its implications for public health management and leadership. It is developed with reference to organizational theories and ideologies, including New Public Management, the use of which has coincided with increasing workplace health problems in health care organizations. The model is based on empirical research and theories in the fields of public health, health care organization and management, and institutional theory. It includes five dimensions and defines organizational health in terms of how an organization is able to cope with the tensions associated with diverse values and competing institutional logics. This definition calls for an understanding of the tensions between values associated with quality, efficiency and integrity, and a dialectical perspective when attempting to assess the integration as well as the disintegration of such values. Possible implications for public health management and leadership include four different forms. The application of the conceptual model can potentially draw attention to value conflicts and help to clarify contradictory, institutional logics. It can also potentially support health managers and professionals in dealing with work health problems not only on an individual and group level, but also on an organizational and interorganizational level.

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